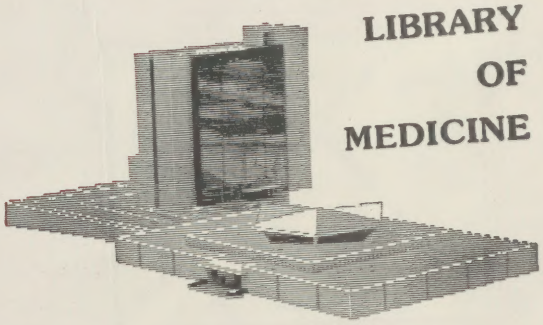
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PART IV

U. S. Bureau of Medicine and Surgery

Administrative history

1941-45

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Chap. 13-16

NAVY MEDICAL DEPARTMENT

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CHAPTER XIII

ADMINISTRATIVE SUPERVISION

The internal functions of a Navy Medical Department facility overseas were placed under the charge of an officer of the Medical Corps, Dental Corps, or Hospital Corps. Usually the senior medical officer of a given command had charge of the Medical Department personnel, facilities, property, supplies, and records of that command. In the absence of a medical officer, an officer of the Dental or Hospital Corps was designated as officer in charge. At small stations or on small ships or vessels where no officers of the Medical, Dental, or Hospital Corps were assigned, an enlisted man of the Hospital Corps had charge of the medical department. At large Navy Medical Department facilities, the officer in charge had administrative assistance from medical and dental officers of lower rank, officers and enlisted men of the Hospital Corps, and to a limited extent, officers of the other staff corps. With the exception of Fleet (Mobile) Hospitals and medical supply depots, medical officers were never in command of independently commissioned units overseas.

All medical officers who had command or charge of Navy Medical Department facilities received their orders from and were directly responsible to officers of the line. From a narrowly legal standpoint, commanding officers exercised administrative authority and supervision over all medical officers in command of fleet hospitals

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and senior medical officers in charge of ship or shore medical departments. From the standpoint of day-to-day practice, of course, these line officers in positions of command had neither the training nor the time to deal with the professional, technical, and scientific matters of medical service; neither did they have the time to concern themselves with the routine functions of Medical Department administration. It was necessary, therefore, for the various commanders, especially those on the higher levels of authority, to delegate the supervision of medical service to medical officers serving on their staffs. Staff medical officers, as representatives of commands superior in authority to the commands to which senior medical officers were immediately responsible, were, therefore, the administrative officers from whom Medical Department officers had technical direction.

During World War II, the number of staff medical officers increased greatly, and as the War progressed, more and more command categories came to have Medical Department representatives on their staffs. By the close of the War, it was the general practice to have medical officers on the staffs of all fleet and force commanders. The senior medical officer on the staff of a fleet commander was generally referred to as the "fleet medical officer" or "fleet surgeon"; the senior staff medical officer for a force commander was called a "force medical officer" or "force surgeon."

The kinds of commands to which fleet, force, and other

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staff medical officers were assigned were various. At the headquarters of the Pacific Fleet, by the end of the War, there were a fleet medical officer for the Pacific Fleet and force medical officers for such commands as the Fleet Marine Force; Amphibious Force; Air Force; Submarine Force; Service Force; Commander, Battleships; Commander Cruisers; and Commander Destroyers. The operating fleets in the Atlantic and Pacific in turn had staff medical officers who served on the staffs of commanding officers of fleets and forces. Commanders of temporary task forces had the assistance of force medical officers; commanders of task groups and units generally had staff assistance from a medical officer. Most commanders of bases and islands, also, had Medical Department personnel assigned to their staffs. Base and island command medical officers usually exercised direct administrative supervision over all Medical Department activities on bases or islands under Navy control.

The duties of staff medical officers differed in detail according to the kind and level of command to which they were assigned. Broadly their duties were substantially the same. They acted as advisors to commanding officers in all matters relating to the health and physical fitness of their commands. They accompanied their commanding officers on general inspection tours and conducted specified and periodical inspections of Medical Department activities under the purview of their commanding officers. They kept their commanding officers informed as to sanitary

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and health conditions. Upon their own initiative or upon orders from their commanding officers or other higher authority, they made special studies of unusual problems or conditions and submitted reports and appropriate recommendations. They gathered and assembled data on Medical Department personnel, facilities, equipment, and supplies of their commands, and kept the proper authorities informed as to the materiel, personnel, and transportation needs of the Medical Department. They assigned or made nominations for the assignment of Medical Department personnel within the jurisdiction of their commands. They furnished professional advice and assistance to medical officers and procured and administered the services of specialized Medical Department units such as the epidemiology and malaria control teams sent out by the Bureau of Medicine and Surgery. They prepared directives and manuals which instructed Medical Department personnel in standardized and approved methods of organization and procedure to be followed on certain types of ships or in certain kinds of naval operations. Staff medical officers assigned to task forces, groups, and units prepared the medical plans for naval operations, established the logistical requirements for the Medical Department, provided for the training and indoctrination of personnel under Medical Department jurisdiction for the duration of the operations, supervised and coordinated medical and casualty evacuation services during the operations, and after the completion of a campaign or

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battle, prepared the medical sections of the action reports.

The command relationships of the average senior medical officer were constantly shifting during the War. The strictly operational chain of command was of course much less stable than the administrative chain. From a purely administrative point of view, he maintained fairly constant communications, if quite remote at times, with the Bureau of Medicine and Surgery, the fleet medical officer of the Atlantic or Pacific Fleet, and the staff medical officer of the type command. Relationships of senior medical officers afloat with the fleet medical officers of the various (numbered) fleets and with staff medical officers of task forces, task groups, task units and other temporary commands were frequently of brief duration. For the shore-based facilities of the Medical Department, the chain of command was more stable but not unchanging. Fleet and bases hospitals, especially those which were transported from one location to another, had changes of command similar to those of ships.

To supplement inspections of Medical Department facilities conducted by commanding officers and by fleet and force medical officers in the Pacific, an Inspector of Medical Department Activities for the Pacific Area was maintained throughout most of the War. The principal duty of this inspector was to keep the Bureau of Medicine and Surgery informed as to the efficiency of logistic support in the Pacific. His duties were distinct from those of the fleet medical

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officer in that his sphere for inspection covered Medical Department activities of the bases established in all the Pacific Ocean areas. The Inspector of Medical Department Activities communicated reports to the Chief of the Bureau of Medicine and Surgery, to the Commander in Chief of the Pacific Fleet and Pacific Ocean Area, to the Commander of the South Pacific Force, and to the Commander of the Seventh Fleet. After completion of a tour of inspection, he returned to Washington, where he had conferences with the Surgeon General and other officials in the Bureau of Medicine and Surgery.

To illustrate in detail the broad generalizations of this chapter, materials abstracted and excerpted from historical and sanitary reports from a variety of specific activities and organizational units are appended herewith in three parts.

The first part, Appendix A, contains abstracts and excerpts which describe or explain the organization, functions, and duties of staff medical officers and their subordinates. In this appendix will be found enumerations of the duties of fleet, force, squadron, group, wing, base, and island command medical officers. In addition, several brief excerpts about special administrative problems such as assignment of personnel and maintenance of medical records in amphibious operations have been included.

In part two, Appendix B, will be found abstracts and excerpts dealing primarily with the relations of ship medical departments to

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higher commands. These describe the constantly shifting operational and administrative chain of command for ships. Some of the reports from the smaller vessels show how senior medical officers of squadrons, divisions, and flotillas exercised administrative as well as professional supervision over the medical departments of vessels which had only hospital corpsmen aboard.

The third part, Appendix C, contains charts which depict in graphic form both the organization of staff medical offices and the relations of ship and shore medical departments to higher commands.

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APPENDIX A

Organization and Functions of Staff Medical Offices

I Duties of the Force Surgeon, Amphibious Force, Pacific Fleet (1942).
II Organization of Staff Medical Office, Administration Command, Amphibious Force, Pacific Fleet.
III Duties assigned to the medical department of the staff of the Commander, Administrative Command, Amphibious Forces, U. S. Pacific Fleet.
IV Functions of Force Medical Officer, Amphibious Force, Eighth Fleet, 1944.
V Duties of staff medical officer of Commander Cruisers, Destroyers Administrative Center, Pacific Fleet.
VI Organization of Staff Medical Office, Submarine Force, Pacific Fleet.
VII Staff medical office of Air Center Command, Pacific.
VIII Duties of staff medical office, Twelfth Fleet.
IX Duties of Force Surgeon, Seventh Amphibious Force, 1943.
X Duties of staff medical office, Service Force, Seventh Fleet, 1943.
XI Duties of Staff Medical Officer, Commander Landing Craft and Bases, Europe.
XII Staff medical office, Marine Aircraft, South Pacific, Fleet Marine Force, 1943.
XIII Administration of Headquarters Squadron.
XIV Duties of the Wing Medical Officer.
XV Squadron and Group Medical Departments.
XVI Malaria and Disease Control Staff, Headquarters, Commander South Pacific, Noumea, New Caledonia.
XVII Preventive medicine organization in Seventh Fleet.
XVIII Assignment of Hospital Corps Personnel, Service Force, Seventh Fleet, 1943.
XIX Duties of an Island Command Medical Officer.
XX Office of Base Medical Officer -- Organization and Functions.
XXI Marine Aircraft Group Twenty-one.
XXII Fourth Marine Aircraft Wing, Fleet Marine Force.
XXIII Medical Records, Amphibious Operations.

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APPENDIX A

Organization and Functions of Staff Medical Offices

I Duties of the Force Surgeon, Amphibious Force, Pacific Fleet (1942)

1. Supervision of amphibious corps medical personnel during their training in landing operations.
2. Supervision of medical needs and operation of AP's, APD's, and AK's.
3. Holding conferences with transport and landing force medical officers directly before operations.
4. Participating in landing operations.
5. Study of medical logistics as related to amphibious operations.
6. Inspection of medical facilities aboard transports and landing craft.
7. Initiating necessary studies and research to improve medical aspects of amphibious operations.

(Abstracted from annual sanitary report for 1942 from Force Surgeon, Amphibious Force, Pacific Fleet.)

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II Organization of Staff Medical Office, Administrative Command, Amphibious Forces, Pacific Fleet

The Commander Administrative Command, Amphibious Forces, Pacific Fleet, was charged by the Commander Amphibious Forces, Pacific Fleet, with the administration of all vessels assigned to the Amphibious Forces, Pacific Fleet, and of all Amphibious Forces bases in the Hawaiian, Marianas, and Philippines areas. He was authorized to deal directly with Cincpac, Comserpac and other appropriate naval and military commands in the discharge of those duties. Adcomphibspac grew out of the Administrative Command, Fifth Amphibious Force, which was established in February 1944. The medical componant of Adcomphibspac was headed by the Force Medical Officer, who assumed the additional duties of medical officer with the administrative command in 1944. He remained at the Administrative Headquarters, however, only between campaigns, during the planning phase. By the beginning of 1945 the scene of operational activity had moved so far west that the Force Medical Officer no longer returned to the Pearl Harbor headquarters of the administrative command, and his duties at Administration headquarters were taken over by a commander, (MC).

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Medical Staff, Administrative Command Amphibious Forces, U. S. Pacific Fleet, 1945.

1 Commander, (MC).
1 Lieutenant, (HC).
2 Pharmacists.
6 Pharmacist's Mates.

(Abstracted from cumulative history report)

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III Duties assigned to the medical department of the staff of the Commander, Administrative Command, Amphibious Forces, U. S. Pacific Fleet.

1. 42 - Medical Officer

(a) Advises the Administrative Commander as to the condition and efficiency of medical departments, health of personnel, and sanitary conditions of all units of the command.
(b) Makes recommendations for the assignment of officer and enlisted medical department personnel.
(c) Compiles medical logistic data.
(d) Is a member of Board of Inspection for ships and bases; arranges and conducts separate medical department inspections of ships and bases.
(e) Receives and processes required medical department reports from the Amphibious Forces, Pacific.
(f) Arranges training and instruction conferences for medical personnel afloat in the area.
(g) Provides medical service for Staff and Flag Detachment.
(h) Prepares medical department reports for Staff and Flag Detachment.

2. 421 - Administrative Assistant to Medical Officer.

(a) Assists medical officer in all administrative matters.
(b) Maintains allowance lists for medical departments of amphibious type ships and craft; prepares allowance lists for special purpose conversions.
(c) Screens medical requisitions from landing craft.
(d) Receives and handles correspondence.

3. 4211 - Medical Personnel and Training Officer.

(a) Maintains card index files of all medical department personnel, officers and enlisted, attached to Amphibious Forces.

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(b) Maintains qualifications files of medical officer specialists and enlisted technicians; furnishes qualifications data to Amphibious Forces and Groups on call.
(c) Processes hospital corps reports from units of Amphibious Forces.
(d) Supervises training of hospital corpsmen in the area.

4. 4212 - Medical Inspections and Statistical Officer.

(a) Assists in medical department inspections.
(b) Maintains file of ships inspected and due for inspection.
(c) Processes casualty, morbidity, and sanitary reports from the Amphibious Forces.
(d) Assembles medical statistical data.

(Extracted from cumulative history report)

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IV Functions of Force Medical Officer, Amphibious Force, Eighth Fleet, 1944.

From a military point of view, highlights of our amphibious operations in the Mediterranean during 1944 included the Anzio invasion in January, the capture of Elba in June, and, in August, the landings on the southern coast of France. In each operation the force medical officer, based on information received from the fleet medical officer, coordinated and integrated medical planning in the form of a medical annex to the General Operation Plan. This annex included a statement of the objectives, procedure for casualty evacuation and hospitalization, medical logistics, and any other information deemed necessary in the execution of the operation.

(Extract from annual sanitary report of the Amphibious Force, U. S. Eighth Fleet, for 1944.)

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V Duties of staff medical office of Commander Cruisers, Destroyers Administrative Center, Pacific Fleet

Duties of the Staff Medical Officer:

1. Advises the Type Commander of the conditions and efficiency of the medical departments, health of personnel, and the sanitary conditions of all units of the command.
2. Makes recommendations to the Type Commander concerning the prevention and checking of disease, and the care and comfort of the sick.

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3. Makes independent sanitary inspections of all units of the command.
4. Accompanies the Commander Destroyers and Cruisers, Pacific Fleet, in all military and material inspections.
5. Holds frequent and informal conferences with the individual medical and dental officers of the various units to keep them informed regarding matters of policy, procedure, changes in personnel, and matters of medical interest and health conditions.
6. Prepares medical guard schedule.
7. Handles surveys of medical stores.
8. Makes recommendations relative to assignment of medical personnel.

Duties of the Underway Medical Officers:

1. Primary duty to board destroyer escorts, under operational control of Commander Air Pacific during carrier training periods, which did not have regularly assigned medical officers.
2. Also supervised the medical care of the personnel of the base and flag allowance.

Duties of the Base Force Medical Officer:

1. Care for the personnel of the base, in conjunction with the underway medical officers.
2. Assist the senior medical officer in inspections of ships of the type command.

Duties of the Administrative Assistant (Chief Pharmacist):

1. Supervise DesCruPac medical department spaces and material.
2. Maintain "uptodate" information on all ships of the command concerning:
   a. dates of inspection
   b. medical officer and enlisted personnel data
   c. ship's medical correspondence: transfer and detachment of medical officers and enlisted personnel.
   d. supplies, account books, narcotics, etc. of the ships inspected by the medical officer.
3. Prepares the final reports of ship's inspections for signature of the chief of staff, or Commander Destroyers, Cruisers, Pacific Fleet.

(Abstracted from cumulative history report.)

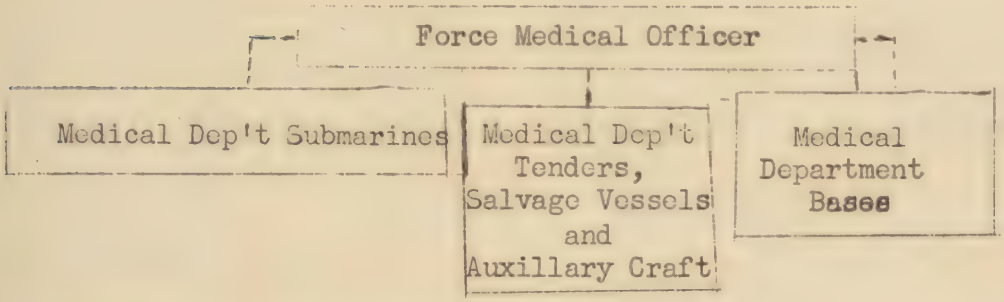
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VI Organization of Staff Medical Office, Submarine Force, Pacific Fleet.

1. Prior to July 1944, the medical department of the Submarine Force, Pacific, "was vested in several individual units consisting mainly of the various squadron medical departments, located at bases or in tenders without an active central controlling activity."
2. From July 1944 to present:

Commander Submarine Force, Pacific Fleet.



(Abstracted from cumulative history report.)

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VII Staff medical office of Air Center Command, Pacific.

The Air Center Command was established in 1943, and a medical department attached to the staff in May.

1. Supervision of aviation dispensaries.
2. Arrangement for evacuation of sick and wounded aviation personnel.
3. Supervision of all flight surgeons.
4. Coordination and supervision of sanitary and malaria control effort in aviation activities.

(Abstracted from historical data supplement to annual sanitary report for 1944 from Air Center Command, Navy Number 145, Pacific.)

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VIII Duties of staff medical office, Twelfth Fleet.

Staff Medical Officer:

1. Responsibility for medical material and personnel from all sources.

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2. Screening of all requests for medical material and personnel from all sources.
3. Advisory help as to medical material and personnel for all U. S. Naval activities in the U. K. or ETO.
4. Coordination of facilities for care of the naval sick in the U. K. or ETO.
5. Coordination of facilities for evacuation of naval casualties from the U. K. or ETO.
6. Dissemination of pertinent information and instructions through appropriate channels to naval medical facilities in the U. K. or ETO.
7. Coordination of necessary reports and returns of the medical department to Washington.
8. Responsibility for the care of the dead, accidents, etc., occurring ashore in the U. K. or ETO, and not locally under cognizance of a U. S. Naval hospital or dispensary.
9. Liaison with all U. S. or Allied medical echelons in the U. K. or ETO.

Personnel of the Office of the Staff Medical Officer, Twelfth Fleet, London:

1. Staff Medical Officer and one assistant.
2. Four officers engaged in chemical warfare instruction and research.
3. One officer in aviation research and observation.
4. Three hospital corps officers and administrative assistants.

Duties of the Staff Medical Officer, Twelfth Fleet in Connection with the Overlord Invasion:

1. Provision of beds for patients at naval bases and base hospitals in the U. K, and establishment of a central reporting and recording system to provide knowledge and control of these beds.
2. Establishment of a central reporting and recording system to provide knowledge and control of patients for evacuation to U. S. and Navy facilities.
3. Establishment of uniform methods of maintenance, medical records of casualties having operations, and their disposition.
4. Training and distribution of medical department personnel designated for casualty handling in LST's.
5. Training and distribution of medical department personnel in the treatment of chemical warfare casualties.
6. Provision for replinishment of medical stores in Navy medical supply storehouses for Navy needs, and maintenance of central stock control records.

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7. Procuring of medical stores to outfit LST's and other vessels to be used for casualty handling in the invasion.
8. Procuring of medical stores to support future operations.
9. Establishment of storage space.
10. Responsibility for the completion and preparation of medical facilities at the various bases.
11. Preparation of the medical logistic plan for the Overlord invasion.

Duties of the Aviation Research and Observation Medical Staff, Twelfth Fleet, London:

1. Observation and investigation of matters of aviation medicine and of special medical importance and reporting of same to the Bureau of Medicine and Surgery, Washington.
2. Maintenance of liaison for the exchange of medical information of mutual benefit to the naval and aviation service of the U. K. and the U. S.
3. Visit to and discussion of aviation medical facilities in the U. K.

(Abstracted from annual sanitary report for 1944 from Commander, Twelfth Fleet.)

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IX Duties of Force Surgeon, Seventh Amphibious Force, 1943

A Force Surgeon was on the staff of the Commander Seventh Amphibious Force, and was charged with the supervision of all medical activities within the command.

1. Supervision of medical facilities in Seventh Amphibious Force training centers.
2. Provision of sufficient and necessary naval medical facilities for amphibious forces afloat.
3. Inspection of all Seventh Amphibious Force medical facilities.
4. Maintaining responsibility for medical supply within the Force.
5. Procuring and assignment of medical department and Hospital Corps personnel within the Force.
6. Assuming responsibility for the maintenance of the general health of the Force.
7. Providing for the study of health conditions and special medical problems indigenous to areas in which Force personnel are stationed.
8. Supervision of sanitation of all Force facilities.
9. Providing for training programs for hospital corpsmen.
10. Providing for the most prompt and efficient system of evacuation in campaigns in which the Force participates.

(Abstracted from annual sanitary report for 1943 from Seventh Amphibious Force.)

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X Duties of staff medical office, Service Force, Seventh Fleet, 1943

Duties of the Medical Department, Service Force Seventh Fleet:

1. Maintenance of medical statistics of the Service Force.
2. Planning of medical department activities of the Service Force.
3. Procurement, distribution, and recording of medical supplies for all activities of the Seventh Fleet.
4. Maintained cognizance of medical aspects of advanced base construction, and public works.
5. Maintained general supervision of hospitals, hospital ships, and dispensaries within the Seventh Fleet orbit.
6. Supervised medical aspects of rest camps and recreation centers.
7. Procurement, assignment and distribution of Hospital Corps personnel for the Seventh Fleet.
8. Maintenance of a Hospital Corps training program.
9. Registration of deaths and graves of deceased personnel of the Seventh Fleet.

Medical Personnel, Service Force Staff, Seventh Fleet:

1 Commander, (MC), USN
2 Lieutenants (j.g.), (HC), USN
2 Chief Pharmacist's Mates
1 Pharmacist's Mate First Class
1 Pharmacist's Mate Second Class
1 Pharmacist's Mate Third Class

(Abstracted from historical data supplement to annual sanitary report for 1943 from Service Force, Seventh Fleet.)

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XI Duties of Staff Medical Officer, Commander Landing Craft and Bases, Europe.

1. Study of the problems associated with LST evacuation.
2. Training of medical officers and corpsmen for duty with LST evacuation of casualties in amphibious operations.
3. Provision for frequent demonstrations in casualty handling procedures.
4. Distribution of medical personnel for casualty handling.
5. Preparation of a "Medical Department Organization and Doctrine for LST's".
6. Provision for medical logistic support for LST evacuation ships.

(Abstracted from "A History of the United States Naval Bases in the United Kingdom".)

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XII Staff medical office, Marine Aircraft, South Pacific, Fleet Marine Force, 1943

"1. Marine Aircraft, South Pacific had its inception in June, 1943, when the need became apparent for a staff to coordinate the widespread activities of Marine aviation units in the South Pacific Theatre of the war. These various units comprise two Aircraft Wings. The Commanding General, First Marine Aircraft Wing, by virtue of seniority, had been in command over all units, regardless of the Wing to which they were attached.

"2. Actually, this has continued to be the nature of the organization, although certain members of the First Marine Aircraft Wing have served additional duty as members of the Staff, Commanding General, Marine Aircraft, South Pacific for purposes of administration. For example, the Wing Surgeon, First Marine Aircraft Wing, also serves as Medical Officer, Marine Aircraft, South Pacific.

. . . . . .

"4. The duties of the Medical Officer, Marine Aircraft, South Pacific, have been entirely administrative and have been concerned largely with the handling of personnel and the formulation of the policies of the medical department."

(Extract from historical data supplement to annual sanitary report for 1943 from Marine Aircraft, South Pacific, Fleet Marine Force.)

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XIII Administration of Headquarters Squadron

Headquarters squadron acts as the administration center for the wing. To it were attached the commanding general, deputy wing commander, chief of staff and all the wing section heads, including the wing medical officer. Their function was the administration of wing affairs. Tactical operations were imposed in combat areas.

Chain of responsibility:

1. Wing Medical Officer
2. Group Medical Officers
3. Squadron Medical Officers

Because of the frequent and distant dispersal of wing units in combat, and due to regional variations of the command, considerable independence of medical action must be allowed in both groups and squadron. In general, however, the wing medical section supervised the procurement of supplies, personnel, and the direction of all broad medical policies within a wing.

(Abstracted from historical data supplement to annual sanitary report for 1943, Headquarters Squadron, Second Marine Aircraft Wing, Fleet Marine Force.)

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XIV Duties of the Wing Medical Officer

1. Responsible for establishment and organization of Wing Medical Activities.
2. Responsible for the general health of wing personnel.
3. Recommends assignment of wing Hospital Corps personnel.
4. Responsible for physical fitness of naval aviators and naval aviation pilots attached to the fleet air wing.
5. Responsible for the care and custody of health records of wing personnel.
6. Responsible for the proper submission of medical reports and returns.
7. Supervision of medical facilities of tenders attached to the fleet air wing.
8. When in fleet air detachment, based at a naval air station, joins with the air station medical department in general medical duties.
9. Training of hospital corpsmen attached to the fleet air wing.
10. Investigation of airplane crashes from a medical standpoint.
11. Instruction of all personnel in first-aid and rescue training.

(Abstracted from historical data supplement to annual sanitary report for 1943 from Fleet Air Wing Four.)

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XV Squadron Group Medical Departments

1. Group Medical Officer - Responsible for the over-all supervision, supply and dispensary facilities for the squadrons.
2. Group medical personnel - Group Medical officer (a flight surgeon or aviation medical examiner).
   Assistant Group Medical Officer (one general duty medical officer)
   One Hospital Corps officers.
   19 hospital corpsmen.
   2 Dental officers.
3. Squadron Medical Department: One Flight Surgeon or aviation medical examiner.
   8 (later reduced to 4) hospital corpsmen.

(Abstracted from historical data supplement to annual sanitary report for 1943 from Marine Aircraft Group 31, Pacific.)

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XVI Malaria and Disease Control Staff, Headquarters, Commander South Pacific, Noumea, New Caledonia

This was the coordinating agency for malaria and disease control throughout the South Pacific area.

1. Carried on and correlated investigations on disease-bearing insects.
2. Maintained a program of sanitation control correlation throughout the area.
3. Preparation and publication of booklets of information and instructions on sanitation and disease.
4. Supervision of all sanitation programs in the area.
5. Coordinate Army and Navy findings on disease and sanitation.

(Abstracted from Report of Inspection of Medical Department Activities in the South Pacific Area -- 1945.)

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XVII Preventive medicine organization in Seventh Fleet

Preventive Medicine Organization consisted of a Fleet Preventive Medical Officer, his assistant, a Fleet Entomologist, and a central Epidemiological Laboratory at Milne Bay, New Guinea. In October 1944 the Fleet Preventive Medical Officer returned to the U. S. and his duties were assumed by the assistant Fleet Medical Officer until a replacement was ordered early in 1945. During the interim the Fleet Entomologist was of great assistance in carrying on field coordination of forward control activities with excellent results.

(Extracted from annual sanitary report for 1944 from Seventh Fleet).

A malaria and epidemic control laboratory has been established at Milne Bay, New Guinea. This is the headquarters of the Malariologist who directs the malaria control program with the assistance of an entomologist. Malariology Units are assigned to Naval Base commanders or to Task Force commanders who have administrative control over advanced operating bases. For administrative control they come under the cognizance of the naval base commander but work under the technical direction of the Malariologist who is attached to the staff of the Seventh Fleet. Epidemological Unit No. 61 recently arrived in this theatre, and is being assigned to the Malaria and Epidemic Control Laboratory.

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The sanitary sections of Construction Battalions are used to provide the manpower for Malaria Control, supplemented at some of the advanced bases by native labor.

(Extracted from letter of the Fleet Medical Officer, Seventh Fleet, to the Chief of the Bureau of Medicine and Surgery, dated 20 February 1944 on the subject: "Medical Department Activities, Seventh Fleet.")

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XVIII Assignment of Hospital Corps Personnel, Service Force, Seventh Fleet, 1943

"Prior to October of 1943, the program for Hospital Corps personnel assignments, rotation of duty or rehabilitation was inadequately controlled by the office of the Force Medical Officer. Records as to authorized or required complements had not been established. The Nav Med HC Forms 4 were the only location records available in the Force Medical Officer's Office. Hence, some activities were under complement, while others were in excess. With the establishment of adequate control files, an advanced Hospital Corps plan and a system of written nominations to the personnel officer, the Hospital Corps situation has been well regulated."

(Extracted from annual sanitary report for 1943 from the Service Force, Seventh Fleet.)

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XIX Duties of an Island Command Medical Officer

Functions of the Staff Medical and Sanitation Officer:

1. Coordination of island medical and dental facilities.
2. Organization and maintainance of adequate island sanitation.
3. Organization of a preventive medicine program.
4. Advising commanding general on Medical Department activities.

Sanitation Duties of the Staff Medical and Sanitation Officer:

1. Eliminating flybreeding areas.
2. Initiation of over-all insect control program.
3. Establishment of adequate measures for garbage and trash disposal.
4. Correction of medical facilities.
5. Controlling of water supply.
6. Establishment of sanitary practices in heads.

(Abstracted from cumulative history report from Staff Medical and Sanitation Officer, Headquarters Island Command, Peleliu.)

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XX Office of Base Medical Officer -- Organization and Functions

1. A Base Medical Officer arrived with the first components which established this base, on 10 February 1945. As gradual growth of this Base took place the additional duties placed upon the G-6 Unit, the original medical activity, clearly became a problem without its jurisdiction.
2. The Base Medical Officer assumed his duties which were:
   (a) The coordination of all Medical activities under the command of the Commanding Officer, Navy Base 3002, Subic Bay.
   (b) Consultant in the planning of future construction projects with regard to their sanitary aspects.
   (c) Supervision of all Preventive Medical Units functioning under command of the Commanding Officer.
   (d) Supervision of activities and plans concerning the Civilian Hospital, Public Health and Venereal Disease Control.
   (e) Coordination of information supplied by all Medical Activities in the Bay Area for statistical purposes and submission of reports.
   (f) Over all supervision of general health and sanitary conditions likely to be of hazard to Navy personnel in the Bay Area.
3. His duties multiplied with the rapid construction of the base especially in the over all supervision of, and recommendations concerning, the sanitary features involved as well as the health and comfort of the men.
4. The Dispensary (G-6) had an especially difficult situation inasmuch as it became necessary to continue its operation in an area originally intended as a temporary measure. Even though the work of this dispensary increased many times it operated with the original field equipment supplied a G-6 unit until late in August 1945. With this in mind request was made to change the designation to a Navy Yard dispensary and a consequent revision of personnel complement and added equipment.
5. Work began upon a new Dispensary in a more favorable location during the month of July which has been completely adequate. Had the originally scheduled plans for the erection of permanent installations been followed, the unsatisfactory conditions referred to would not have been present. However, along with other projected construction work, all work ceased with the withdrawal of the 115th C. B. BATTALION for high priority construction elsewhere.

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Organization

FUNCTION

1. The function of the base Medical Officer shall be as follows:

(a) As the Staff Medical Officer at Commander Naval Base, Navy 3002, he shall exercise coordinative control of the medical activities of all components of this command. He shall maintain a well integrated relationship between such medical activities, and shall have authority to make such inspections as are considered necessary to determine that they are functioning properly.

(b) As the Port Medical Officer, he shall ensure that port sanitary regulations are carried out by forces afloat, and shall act as liaison between medical activities ashore and those afloat, providing medical services for forces afloat as necessary.

(c) He shall supervise and generally direct the activities of the Preventive Medicine Department of this base.

(d) He shall keep the Base Commander informed on the current health and sanitation status of the base and shall make appropriate recommendations on any pertinent corrective measures considered advisable.

(e) He shall act for the Base Commander in supervision of the general activities of, and planning for, the Civilian Hospital and the Civilian Public Health Department on the reservation.

(f) He shall collect and coordinate information supplied by all the medical activities of the Base for statistical purposes and submission of appropriate reports.

(g) He shall act as medical and sanitation consultant in current Base Maintenance and future planning.

(h) He shall be responsible to the Base Commander for the over-all supervision of general health and maintenance of satisfactory sanitary conditions of the Naval Personnel of the Command.

BASE MEDICAL COMPONENTS

2. Base activities under the direction of the Base Medical Officer are grouped as follows:

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A. Preventive Medicine.
B. Dispensary Facility.
C. Dental Facility.
D. Civilian Hospital and related civilian health and sanitation problems.
E. Medical Storehouse.

The Base Medical Officer shall be the coordinating principal through whom all component activities shall have liaison with each other. Monthly statistical reports of each activity, including data upon projects completed, in progress or proposed shall be submitted to the Commander Naval Base via the Base Medical Officer.

PREVENTIVE MEDICINE

3. The designated Preventive Medical Officer shall assume responsibility as head of an organized Public Health Department. All related functional units, including Base Sanitation, Epidemiology, Venereal Disease Control, Malaria Control and Rodent Control shall be under his immediate direction.

His activities are intended to function in an over-all supervisory capacity for the entire Naval Reservation and naval installations immediately adjacent thereto under command of Commander Naval Base.

DISPENSARY FACILITY (BASE)

4. The organization of the base dispensary shall be in accordance with the Manual of the Medical Department, with specific references to those provisions of the Manual pertaining to the duties of the Medical Officer of a shore station. Details of operation of this dispensary shall be those as set forth in the organization plan of the base dispensary.

Associated with the base dispensary, shall be the sub-dispensary at the Ship Repair Unit whose personnel shall be derived from and be responsible to the Naval Base Dispensary.

First aid stations at locations established by the Base Medical Officer as changing needs require, shall be under the cognizance of the Base Dispensary from which personnel and supplies shall be drawn.

Additional duties required of medical officers for Boards of Survey, Investigation, or other such boards convened by Commander Naval Base shall be fulfilled by those medical officers nominated for such duties by the Senior Medical Officer, Base Dispensary.

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(C. B. UNITS) As the staff medical representative of Commander Naval Base, the Base Medical Officer is responsible for the proper collection of statistical data, monthly morbidity reports and over-all supervision of health and sanitary features of all construction battalion units.

DENTAL FACILITY 5. All dental activities under the command of Commander Naval Base are under the immediate supervision of the Base Dental Officer, who in turn, is responsible to the Base Medical Officer.

Reports of dental services are to be prepared and forwarded by the Base Dental Officer, according to the provisions of the Manual of the Medical Department.

An organization plan governing the details of operation shall be the instructional guide for the dental facility.

CIVILIAN HOSPITAL AND RELATED CIVILIAN HEALTH AND SANITATION PROBLEMS 6. The Civilian Hospital shall be under the direction of a designated Medical Officer as regards clinical aspects and care of patients. Employment, procurement of materials, general supplies, and some medical supplies shall be handled by the Civil Affairs Officer with the Civil Affairs Medical Officer acting as liaison. General facilities of the hospital shall be governed by Civil Affairs and the Hospital Board, with advice and recommendations of the medical department via the Base Medical Officer.

Public Health and sanitation relating to civilians shall be under the direction of the Civilian Affairs Medical Officer with the facilities of the Epidemiology laboratory available upon request.

MEDICAL STOREHOUSE 7. Directional supervision of the Medical Storehouse is vested in the Base Medical Officer.

OUTLYING DISPENSARIES 8. The Base Medical Officer shall exercise coordinative control over all dispensaries of the separate commands of this Naval Base. This includes at present, Naval Supply Depot, Receiving Station, Staging and Discharge Centers and Construction Battalion Camps.

(Extracted from cumulative history report)

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XXI Marine Aircraft Group Twenty-one:

Marine Aircraft Group Thirty One (MAG 31) was originally organized with a headquarters squadron, and a service squadron, and one (1) tactical squadron (VMF 311). By the time the Group was alerted for overseas duty, four (4) more tactical squadrons had been attached (VMF 312), (VMF 321), (VMSB 331), and (VMSB 341). This comprised the tactical group, under the over - all command of the Group Commander.

The Medical Department was similarly organized; the Group Medical Officer has been responsible for over-all supervision, supply and dispensary facilities for the squadron. Each Squadron Medical Department consisted of one flight surgeon or aviation medical examiner and eight (8) corpsmen (later reduced to four (4) corpsmen). The Group Medical Department has had higher complements, consisting in the first portion of the year of the Group Medical Officer (flight surgeon or aviation medical examiner). One general duty Medical Officer as assistant, one Hospital Corps Officer and nineteen (19) Hospital Corpsmen. In the later portion of the year the extra Medical Officer was eliminated. The Dental Department has consisted of two (2) Dental Officers, and sufficient Corpsmen as detailed by the Group.

The Group has been under the control of the Marine Aircraft Wing; the responsible Wing changed with each change in location of the Group. While in the Samoan area, the Fourth Marine Base Defense Aircraft Wing was the next higher echelon; from the time of the move to Okinawa until the present, the Second Marine Aircraft Wing has been the over-all command."

(Extract from cumulative history report).

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XXII Fourth Marine Aircraft Wing, Fleet Marine Force:

"The Medical Department of the Fourth Marine Aircraft Wing has functioned primarily in an administrative capacity, directing the activity of the various medical departments of the Groups within the Wing. This department has administered the medical needs and directed the sanitation practices of this organization of approximately 700 personnel."

(Cumulative history report)

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XXIII Medical Records, Amphibious Operations:

During the follow-up of the Anzio assault, some health records were lost due to loss of ships on which they were carried. Preparation of new records to replace those lost was time consuming. To prevent a repetition of this, before the invasion of Southern France, "Medical Records Administrative Offices" were set up ashore for type ships. In the custody of a pharmacist's mate were placed all health records, the pharmacist mate of the individual ship retaining on board a copy of the inoculation record of each man, and an extract of any information which the medical officer considered important. Such offices were established for LST's, LCI's, LCT's and the Escort Sweeper Group (PC, YMS, SC, AM, etc.). Miscellaneous ships not in one of these groups were instructed to place their health records ashore for safekeeping at one of the bases under this command. After a month or six weeks--when it became apparent that further ship losses would be minimal--these administrative offices were dissolved and the records returned to the ships.

(Extracted from annual sanitary report of the Amphibious Force, U. S. Eighth Fleet, for 1944.)

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Temporary shore bases in Italy were established by the 8th Amphibious Force at Nisida and Pozzuoli to expedite the activities incident to the Anzio and Southern France operations. Since these are on the outskirts of Naples no attempt was made to set up dispensaries in either place. However, a medical administrative office was established in Pozzuoli through which the ships made contact with the Naval Dispensary, Naples and the various Army hospitals used by the Navy for hospitalizing sick and wounded naval personnel. The medical administrative office assumed the custody of all health records of personnel attached to ships and small craft of the Amphibious Force. This was done to safeguard records against loss, since these ships were operating in an active combat area and on several occasions records were lost or destroyed as the result of enemy action. Skeleton records were kept aboard all ships but the health records themselves were kept ashore and maintained according to Navy Regulations by the staff of the medical administrative office. This activity ceased to function when these activities were no longer required for tactical reasons and the records were transferred back to the various ships.

(Annual sanitary report from Fleet Medical Officer, United States Eighth Fleet, for 1944.)

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Prior to D-day Vicarage Road Camp, U. S. Naval Advanced Amphibious Base, Plymouth, was set up as a survivors camp. Records of all personnel aboard ships and craft of the 11th Amphibious Force were collected there in a Central Record Office. A Medical Casualty Record Section under Commander, Landing Craft and Bases, Eleventh Amphibious Force was installed for the compilation from the Running Record of Battle Casualties, a list by name, number and craft of all U. S. Naval dead, missing and wounded for submission to the various task forces involved in OPERATION OVERLORD. This activity was moved to the Headquarters, Commander, Amphibious Bases, United Kingdom in July 1944 and at present is carried on in the Staff Medical Office. It has been of inestimable value in obtaining accurate records and in tracing missing personnel.

(Extracted from annual sanitary report of Commander, Amphibious Bases, United Kingdom, for year 1944.)

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APPENDIX B

Relations of Ship Medical Departments to Higher Commands

I	USS NORTH CAROLINA
II	USS TICONDEROGA
III	USS WASP
IV	USS SHANGRI-LA
V	MISSION BAY
VI	USS WAKE ISLAND
VII	USS SARGENT BAY
VIII	USS SITKOH BAY
IX	THETIS BAY
X	USS SAN FRANCISCO
XI	USS GUAM
XII	USS FLINT
XIII	WILKES-BARRE
XIV	USS CONWAY
XV	USS EATON
XVI	USS DORTCH
XVII	USS FRANK KNOX
XVIII	USS HOBBY
XIX	USS HAVERFIELD
XX	USS WATERMAN
XXI	USS FLASHER
XXII	USS CASCO
XXIII	USS RIXEY
XXIV	USS FREMONT
XXV	USS BOLIVAR
XXVI	USS PRAIRIE
XXVII	USS PELIAS
XXVIII	USS GRIFFIN
XXIX	USS SPERRY
XXX	USS ROCKY MOUNT
XXXI	USS HENRY A WILEY
XXXII	USS RELIEF
XXXIII	USS BOUNTIFUL
XXXIV	LST(H)464
XXXV	USS CASA GRANDE
XXXVI	LCI(L)954
XXXVII	LCI (5), Flotilla Ten
XXXVIII	LCI(L)188, Flagship, LCI Group One, Flotilla One.

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I. USS NORTH CAROLINA (BB55)

"For administration and combat purposes, this battleship usually operated with one or two other battleships of similar design and class of speed to form a battleship division. This battleship division was under the command of a battleship division commander usually a Rear Admiral. Several battleship divisions in turn were grouped under the command of a battleship squadron commander.

"The Fleet Commanders received their orders from the Commander in Chief of the United States Pacific Fleet (CincPac) and Pacific Ocean Areas (CincPoa).

"As illustrated in the actions described in the history of this ship, this vessel performed many functions. She usually operated with a fast carrier force but also performed shore bombardment in support of amphibious operations. She made day and night surface engagements with the enemy and raided enemy shipping and their homeland. She protected our troop convoys and gave medical aid to other ships of the fleet especially destroyers.

"Because of the many types of missions this vessel engaged in, for operational purposes, the chain of command would shift to the Task Force Commander who had been designated for that mission, regardless of relative rank.

"The Medical Department followed the administration and operational chain of command as described.

"The Fleet Medical Officer and the Medical Officers on the Staff of the Task Force Commanders and Type Force Commanders were informed of all necessary medical information pertinent to their commands. However, routine official medical department correspondence to the Headquarters of the Commander in Chief United States Pacific Fleet and Pacific Ocean Areas was routed via them only if so directed.

"As this vessel operated with a fast carrier task force all of the casualties treated were men of our own crew or from other ships of the task force. This ship did not receive casualties from the beach during amphibious operations. Chronic or complicated cases were treated aboard until contact could be made with a hospital ship or they could be transferred to a Naval Hospital." (Cumulative history report.)

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II. TICONDEROGA (CV 14)

"This vessel's organization is that of all Essex class carriers. During the period covered by this report it has operated with the Third and Fifth Fleets, in various task groups as assigned. This vessel's position in the chain of command varied widely in accordance with orders issued to the task group; at various times she was a flagship, at other times as a participant in a larger task group." (Cumulative history report.)

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III. USS WASP (CV 18)

"The ship's position in the Naval Chain of Command varied in accordance to seniority of Flag and commanding officers attached to the Task Unit or Task Group when it was formed by various sources of high authority. At times, when the WASP carried the Commander of a Task Unit or even of a Task Group her position in the Chain of Command graduated toward the top. At other times when the flag was located aboard another vessel of which the WASP was a member of a Task Unit, her position depreciated accordingly.

"This ship did not stay in any one Task Group or Task Unit for any length of time, being continually separated from one unit and ordered to another as operations and fleet manuevers necessitated. The WASP was, except when being removed from the forward area, attached either to Task Group 58 or Task Group 38, depending on which Fleet was at the time in the forward area conducting attacks against the enemy. Her further segregation as regards Task Units within the Task Group was usually changed after completion of her assigned mission.

"Primarily the WASP came under the orders of CincPac and ComAirPac in that order.

"....The Naval Chain of Command insofar as the Medical Department was concerned depended whether the Task Group and/or Task Unit Commander and his staff (which included a Medical Officer) had his flag aboard the ship or some other. Notwithstanding those fluctuations, the Medical Department came under the Medical Officer, ComAirPac, who in turn came under the Fleet Medical Officer, CincPac." (Cumulative history report.)

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IV. USS SHANGRI-LA (CV 38)

"This basic organization was augmented by an additional Medical Officer (Flight Surgeon) whenever an Air Group was embarked. The Senior Medical Officer and one other Medical Officer in the ship's organization were also Flight Surgeons. The Senior Medical Officer acted as one of the ship's departments heads, and received his orders from the Commanding Officer or the Executive Officer. The Air Group Flight Surgeon, when aboard, functioned as a member of the ship's Medical Organization in addition to his duties with the Air Group.

"The chain of command under which the ship operated, varied according to the locale of the ship and according to task force and fleet organization. Upon commissioning and while undergoing shakedown and trial cruises in the Atlantic, the ship operated down through the chain of command from Cinclant, via Comairlant, to Comfairnorfolk. Upon transit of the Panama Canal the chain of command changed to Cincpac, via Comairpac to Comfairwestcoast. Upon arriving at Pearl Harbor the ship reported to Comairpac for duty, and still later reported to Commander 5th Fleet in the forward area for duty with Task Force 58 on 24 April 1945. The designation of Task Force 58 was changed on 28 May 1945 to Task Force 38 and the ship reported to Commander 3rd Fleet for duty. The ship remained a part of the 3rd Fleet until the conclusion of the war. Throughout this entire period the SHANGRI-LA operated under numerous relatively minor task force or task group designations for specific tasks." (Cumulative history report.)

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V. MISSION BAY (CVE 59)

"The Medical Department of the ship operated almost exclusively under directives and despatches from CinCPac through the Fleet Medical Officer and from ComAirPac through the Force Medical Officer. Enlisted Hospital Corps personnel were transferred and received through the authority of ComAirPac and ComFair, WC under the direction of the command now designated as ComWesFron." (Extract from cumulative history report.)

VI. USS WAKE ISLAND (CVE 65)

"The Medical Department functioned as integral component of the ships organization and its subsequent activity paralleled therefore, the assignment of the ship to various fleet divisions and duties. Following a shakedown cruise, the ship

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went to the East Coast and was attached to a carrier division of the Atlantic Fleet under ComAirLant. One ferry trip was made to Karachi, India, followed by two months duty on anti-sub patrol and two months training duty out of Quonset. In November 1944 the ship departed for the West Coast via the Panama Canal and was assigned to various carrier divisions of the Pacific Fleet under ComAirPac. During the ensuing period to the end of the war the ship operated as a member of various carrier task units first with the 7th Fleet during the Luzon Invasion, then with the 5th during the Iwo Jima campaign and finally with the 3rd Fleet during the Okinawa operation." (Cumulative history report.)

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VII. USS SARGENT BAY (CVE 83)

"The U. S. S. SARGENT BAY operated the entire time in the Pacific. The position of the ship in the naval chain of command was as follows:

(1) Commander in Chief, United States Fleet.
(2) Commander in Chief, Pacific Fleet
(3) Commander Air Force, Pacific Fleet
(4) Commander Third Fleet
(5) Commander Fifth Fleet

"During the several operations in which the ship took part in the Pacific the ship has been assigned to various task groups and task units as listed...." (Cumulative history report.)

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VIII. USS SITKOH BAY (CVE 86)

"The USS SITKOH BAY served under the following chain of command for the greater portion of the war:

Commander in Chief, U. S. Fleet
Commander in Chief, U. S. Pacific Fleet
Commander Air Force, Pacific Fleet
Commander Carrier Transport Squadron, Pacific

"During its service under the above commands and while carrying out its function as a transport, training, and replenishment carrier this vessel was attached to various Task Groups and Task Units that are not listed above."

"The SITKOH BAY has operated as a unit of Carrier Transport Squadron, Pacific Fleet. This vessel has functioned as a transport aircraft carrier to supply the far-flung Pacific

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naval bases, as a replenishment carrier to supply replacement aircraft to units of the Fleet engaged in making strikes upon the enemy, and as a qualification carrier to afford pilots carrier experience." (Extracts from cumulative history report.)

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IX. THETIS BAY (CVE 90)

THETIS BAY: Chain while on transport duty 21 April 1944 to June 1945.

The Commanding Officer, USS THETIS BAY
The Commander, Carrier Transport Squadrons, Pacific
The Commander, Air Force, Pacific Fleet
The Commander in Chief, Pacific Fleet
The Chief of Naval Operations

While on replenishment duty, according to type, 27 June to 6 September 1945.

The Commanding Officer, USS THETIS BAY
The Commander, Carrier Transport Squadrons, Pacific
The Commander, Air Force, Pacific Fleet
The Commander in Chief, Pacific Fleet
The Chief of Naval Operations

While on replenishment duty, operational 27 June 1945 to 6 September 1945.

Commanding Officer, USS THETIS BAY
Commander, Task Group 30.8
The Commander, Third Fleet
Commander in Chief, Pacific Fleet
Chief of Naval Operations
(Cumulative history report.)

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X. USS SAN FRANCISCO (CA 38)

Tactical

Pacific Fleet
Cruisers, Pacific Fleet
Cruiser Division #6

Administrative

Bureau of Medicine and Surgery

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Fleet Surgeon, Pacific Fleet
Fleet Surgeon, Third, Fifth, or Seventh Fleet
Cruiser Division #6 Medical Officer

(Cumulative history report.)

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XI. USS GUAM (CB 2)

"It should be stated that the Naval Medical Bulletin, BuMed News Letter and the Pacific Fleet Medical News were of inestimable value in not only keeping us informed of problems encountered and handled well by other ships as well as in making available information on new and changing concepts of treatment." (Cumulative history report.)

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XII. USS FLINT (CL 97)

"The Medical Department of the USS FLINT (CL 97) operated as a single department under the direct supervision of the medical officer. Coordination with other departments and with fleet activities was directed by the Commanding Officer. Department reports were sent to the Bureau of Medicine and Surgery either directly or through Commander Cruisers, Pacific. The USS FLINT operated throughout the period covered by this report as a combatant unit of the 3rd, 5th Fleet with administration through Commander, Cruisers, Pacific." (Cumulative history report.)

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XIII. USS WILKES-BARRE (CL 103)

Tactical:

Pacific Fleet
Commander Cruisers, Pacific Fleet
Cruiser Division #17

Administrative:

Bureau of Medicine and Surgery
Fleet Surgeon, Pacific Fleet
Fleet Surgeon, Third, Fifth, and Seventh Fleet
Cruiser Division #17 Medical Officer

(Cumulative history report.)

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XIV. USS CONWAY (DD 507)

"This ship is a 2100 ton destroyer and has been the Flagship of the Commander, Destroyer Division Forty-Four from the time of its entry into the Pacific Theater of war until that division was changed to DesDiv 302 in the Inactive Reserve Atlantic Fleet on 1 January 1946. The CONWAY and eight other destroyers of the class operated in the Pacific as Destroyer Squadron Twenty-two. The entire squadron operated under the Commanders, Third and Fifth Fleets from early in December 1942 until ordered as a unit back to the United States in August 1944....Upon return to the Pacific, DesRon 22 operated under the Commander, Seventh Fleet, until detached in December 1945 to enter the Reserve Fleet. For administrative purposes, the CONWAY served under Commander, Destroyers, Pacific Fleet, along with all other ships of this type, and the destroyer tenders in that Fleet." (Cumulative history report.)

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XV. USS EATON (DD 510)

"The USS EATON is a unit of Commander Destroyer Division 44 and Commander Destroyer Squadron 22. While in the forward area prior to return to the United States in August 1944 the Eaton was under Commander South Pacific Area and operated with the Third and Fifth Fleets. On resuming operations in the forward area in November 1944 it was listed under the administrative command of Commander Seventh Fleet. With the exception of the commissioning and shakedown training period all activity has been in the Pacific Area under the Commander in Chief, U. S. Pacific Fleet, with Commander Destroyers, U. S. Pacific Fleet as type commander." (Cumulative history report.)

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XVI. USS DORTCH (DD 670)

"The USS DORTCH (DD 670), one of nine ships of DesRon 50, which is under the command of Commander Destroyers, Pacific Fleet, operated with Carrier Task Force 58 and 38 during almost her entire period of activity. A number of independent missions were also carried out by the DORTCH and other ships of her division.

"During the war, each destroyer had one medical officer who was assisted by two to three pharmacist's mates. The medical officer was directly responsible to the commanding

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officer of this vessel and thru him to the Commander Destroyers, Pacific Fleet, and the Bureau of Medicine and Surgery." (Cumulative history report.)

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XVII. USS FRANK KNOX (DD 742)

"At present there is a Division Medical Officer aboard the USS SOUTHERLAND who is in charge of the medical activities aboard four destroyers. He is available should any situation out of the scope of the pharmacist's mates aboard arise." (Cumulative history report.)

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XVIII. USS HOBBY (DD 610)

"The medical activities of the ship are independent with the exception of periodic timely literature from the Type Commander of the Atlantic or the Pacific Fleets, and the Bureau of Medicine and Surgery. The activities aboard have been previously guided by Navy Regulations, Manual of the Medical Department, and recently by the Destroyer Medical Guide, issued by the Commander Destroyers, Pacific Fleet, U. S. Navy.1945." (Cumulative history report.)

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XIX. USS HAVERFIELD (DE 393)

"The medical department of this vessel was important to the other escorts of the group, for with the Division Medical Officer aboard it was the center of all medical activities. The medical officers special equipment was set up and rendered service to the other medical departments of the Task Group, helping to solve the intricate clinical situations that arose." (Cumulative history report.)

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XX. USS TINSMAN (DE 589)

"A medical officer under the command of Commander Escort Division 71 served the division consisting of six ships. Supervision of the Division Doctor was effected by periodic inspections of this ship and medical assistance, operations permitting." (Cumulative history report.)

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XXI. USS WATERMAN (DE 740)

There were six ships in the division to which this destroyer escort was attached. Each ship usually had a chief pharmacist's mate and a pharmacist's mate first class aboard. The division doctor spent most of his time on the flag ship, but rotated among the other ships; about two months out of the year were spent on the WATERMAN. Each chief pharmacist's mate was responsible for the medical department of his own ship, and reported to the division doctor, who acted as head of the medical staff for the division. (Abstracted from cumulative history report.)

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XXII. USS FLASHER (SS 249)

"The Medical Department representative on the USS FLASHER Consisted of one Pharmacist Mate and was under the direct cognizance of the Squadron Medical Officer, the Force Surgeon, Service Force, Seventh Fleet and the Senior Medical Officer, Commander Service Force, Subordinate Command, Pacific Fleet. Copies of all reports were submitted to these commands with the exception of the Squadron Medical Officer who did not require them." (Extract from cumulative history report.)

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XXIII. USS CASCO (AVP 12)

"Until 2 October 1944, the ship was under the supervision of ComAirWing Two with the administrative duties being handled at first by ComForwardArea and later by ComMarshallSubArea and ComMar-GilAreas. Since 2 October 1944, command has changed to ComFlairWing One who has also handled the administrative duties of the command. Medical reports were mailed to the Staff Medical Officer of ComSERVForPac, ComServForPacSubCom, CincPac and ComAirPac." (Cumulative history report.)

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XXIV. USS RIXEY (APH 3)

"In the early part of the war and after the war ended, the ship was attached to Commander Service Force Command of the Pacific, operating independently and carrying troops and passengers or evacuating patients.

"In preparation for invasions the RIXEY joined one of the Amphibious forces as a member of a transport squadron, being

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under the control of the Attack Task Force Command for use as an Assault Transport in the first phase of the amphibious operation. On the arrival at the beach and after discharging her troops she was prepared to receive casualties from the beach or adjacent ships. When loaded with casualties she was sailed by S.C.P.A. or other Attack Force Commands as directed in the operational plan. Then Commander Service Force assumed control and directed the ship to definite ports according to the load. Upon discharge of casualties and after servicing the ship it was again sailed by Commander Service Force to a port as designated in the operational plan, or was directed by the Attack Force Command to await a call forward to the objective area." (Extracted from cumulative history report.)

- - - - - -

XXV. USS FREMONT (APA 44)

"Although the ship functioned as a flagship during operations the medical department of the ship had no administrative duties but was assigned the care of casualties the same as medical departments of other APA's." (Cumulative history report.)

- - - - - -

XXVI. USS BOLIVAR (APA 34)

"The Senior Medical Officer of this ship has acted as Transport Division Medical Officer in all operations. He had adjusted personnel requirements within the division to meet the existing needs of various ships and has coordinated evacuation of casualties from the combat area." (Cumulative history report.)

- - - - - -

XXVII. USS PRAIRIE (AD 15)

"The function of this ship is to furnish tender services to destroyers and destroyer escorts. For the last ten months of the year, this ship together with other AD's were stationed at three different anchorages where shore based hospital facilities were not available....With the approval of the Commanding Officer of the USS PRAIRIE, the Commander of Service Squadron Ten verbally ordered the Senior Medical Officer of this vessel to set up an organization for handling and coordinating medical services and hospital facilities. He also desig-

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nated him as anchorage evacuation officer and medical representative of ComSerRonTen." (Cumulative history report.)

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XXVIII. USS PELIAS (AS 14)

"The Senior Medical Officer has performed duty as Head of the Medical Department, and has been in direct charge of the treatment of the sick and injured, also in charge of medical supplies, and has closely watched the sanitary condition of the ship and area, and general health of the crew. He has also been in direct charge of the health of the submarine crews, during refit periods, and the sanitary condition of the submarines. He has had additional duty as squadron medical officer, for Submarine Squadron Six, and temporarily for Submarine Squadron Sixteen pending arrival of their tender." (Cumulative history report.)

- - - - - -

XXVIX. USS GRIFFIN (AS 13)

"The Senior Medical Officer was head of the Medical Department. As Squadron Medical Officer he served in an advisory capacity in all matters pertaining to the care of the sick and wounded, and health and hygiene of the submarines. The USS GRIFFIN Medical Department carried out all the usual activities relating to the ship and provided medical and dental facilities for personnel attached to submarines, and medical stores for issue to submarines. In view of the fact that submarines operate for extended periods of time away from the tender, every effort was made to eliminate or repair the physically or mentally unfit. This was carried out by frequent and repeated physical examinations and psychiatric interviews with the submariners." (Cumulative history report.)

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XXX. USS SPERRY (AS 12)

"The medical officer of the SPERRY is the administrative head of the department and has been assigned additional duty as Squadron Medical Officer, Submarine Squadron 10....The medical officer, acting in the capacity of Squadron Medical Officer, has had more or less complete charge of assigning Pharmacist's Mates to independent duty aboard the submarines of the Squadron as well as other submarines which may have been overhauled by the SPERRY." (Historical data supplement to annual sanitary report for 1943.)

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XXXI. USS ROCKY MOUNT (AGC 3)

This ship was an auxiliary general communications type ship; her primary function was that of a command ship for amphibious forces.

"Throughout all the campaigns in which the ROCKY MOUNT took part the ship's Medical Department treated large numbers of casualties of all types. The Staff Medical Officer directed the overall handling of casualties.

"At Lingayen the ROCKY MOUNT acted as SOPA (Administrative) and held sick call and consultations for the smaller vessels." (Cumulative history report.)

- - - - - -

XXXII. USS HENRY A. WILEY (DM 29)

"This ship has been under the Administrative Command of the Commander Minecraft, U. S. Pacific Fleet since it entered the Pacific theater. The Staff Medical Officer has at all times been most helpful when called upon for aid. In the two campaigns thru which it has served, this vessel has been for the most part under operational control of the assault task force commanders of the 3rd and 5th Fleets whose organizations made available either hospital ships or APA's for receiving casualties requiring more aid than could be given on a ship of this type." (Cumulative history report.)

XXXIII. USS RELIEF (AH 1)

In 1942, following a general reorganization of the fleet, the RELIEF operated under Commander Service Forces Pacific, Commander Service Squadron Ten, and various Service Division Commanders. On occasions, when conditions required, the ship operated directly under Commander in Chief, Pacific Fleet, who sometimes assigned her to subordinate commanders for special duties. (Abstracted from cumulative history report.)

- - - - - -

XXXIV. USS BOUNTIFUL (AH 9)

"During the major portion of the time, the ship has served as a part of the Service Force, U. S. Pacific Fleet, and through that chain of command, under the respective Commanders of the Third and Seventh Fleets." (Cumulative history report.)

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XXXV. USS LST(H) 464

"From the date of arrival in Sydney, Australia, until the end of the war, the ship was assigned to the Seventh Amphibious Force and received its orders from Commander, Seventh Amphibious Force, under the overall command of the Seventh Fleet. Nominally assigned to LST Flotilla Seven, she never participated in group or flotilla movements, but served independently where she was most needed under the direct command of Commander, Seventh Amphibious Force.

"Just where the USS LST 464 stands in the organization of the Medical Department is as ambiguous as it is amphibious." (Cumulative history report.)

- - - - - -

XXXVI. USS CASA GRANDE (LSD 13)

"The duties of the Medical Department and its personnel are determined by Navy Regulations, the Manual of the Medical Department and the Landing Ship Dock Organization Book, and by modifications that have originated from various area commanders and task groups that this ship has served under as outline.... There is no type commander for landing ship docks as yet." (Cumulative history report.)

- - - - - -

XXXVII. USS LCI(L) 954

"During the invasion of Southern France a medical officer was assigned to this vessel as part of the ship's company. Since this vessel became command ship for the LCT Type Commander at least one medical officer attached to that officer's staff has been aboard at all times though such medical officers have not been assigned to this vessel for duty." (Cumulative history report.)

- - - - - -

XXXVIII. USS LCT (5) Flotilla Ten

Flotilla Ten consisted of forty-six LCT's..

"Due to the fact LCT's have been deployed over a wide area on independent duty it has made it impossible for the medical department of this command to keep accurate records. There are times when we do not see some of these craft from three to

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to four months. Men who have fallen sick during these times away from Flotilla 10 Headquarters have been treated or hospitalized at the nearest available U. S. Navy or U. S. Army dispensary or hospital. No records were forwarded to this command of treatment, diagnosis, length of time hospitalized, etc.....

"Letters were sent to all crew commanders instructing them to submit a written report to the Medical Officer of this command with all the details of casualties, illness, treatment, or hospitalization of any of their crew while on independent duty away from Flotilla Headquarters.....A letter was sent to each crew commander with attached sheet listing his men and shots they needed....When shots were given, medical officer or corpsmen signed attached sheet and crew commander in turn forwarded it back to the Flotilla Medical Department and it was entered into man's health record.

....

"Each flotilla consists of three groups, with twelve LCT's to a group. The medical complement of each group consists of one doctor and two Pharmacist's Mates first or second class with a sum total of three doctors and six pharmacist's Mates to a flotilla."

(Extracts from historical data supplement to annual sanitary report for 1943 from LCT(5) Flotilla Ten.)

- - - - - - - -

XXXIX. USS LCI(L) 188, Flagship, LCI Group One, Flotilla One

"Each member of the medical unit was embarked on board a different ship of the group thus affording medical department supervision for five out of twelve ships with occasional shifting of medical personnel as emergencies demanded. Pharmacist's mates were thus in a status of independent duty, and only when all ships of the group were together in port was it possible for the medical officer to exercise direct supervision of their activities. He was often out of touch with one or all of the pharmacist's mates for periods of weeks at a time."

(Extracted from historical data supplement to annual sanitary report for 1944 from LCI(L) 188, Flagship, LCI Group One, Flotilla One.)

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APPENDIX C

Charts

I	Force Medical Office, Service Force, Pacific Fleet.
II	Office of the Commander, Administrative Command, Amphibious Forces, U. S. Pacific Fleet.
III	Sixth Amphibious Force.
IV	Sixth Amphibious Force.
V	Administrative and operational relationships of the USS NASSAU (CVE 16).
VI	Administrative and operational relationships of the USS REDNOUR (APD 102).
VII	Malaria and epidemic control South Pacific.
VIII	Commander, Training Command, Pacific.
IX	Navy Medical Department Organization, Kodiak Sector.
X	Navy Medical Department Organization, Unalaska Sub-Sector.
XI	Navy Medical Department Activities, U. S. Naval Base, Subic Bay, Philippine Islands.
XII	U. S. Naval Operating Base, Oran, Algeria.
XIII	U. S. Military Government Unit, Saipan, M. I.
XIV	Base Hospital 2 -- position in chain of command while located at Efate, New Hebrides.
XV	Base Hospital 2 -- position in chain of command while at Noumea, New Caledonia.
XVI	Base Hospital 2 -- position in chain of command while at Subic Bay, P. I., under Seventh Fleet.
XVII	Base Hospital 2 -- position in chain of command while at Subic Bay, P. I., under Commander Philippine Sea Frontier.

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ORGANIZATION CHART
FORCE MEDICAL OFFICE, SERVICE FORCE
PACIFIC FLEET



Administers medical and dental officer pool. Nominates medical and dental officers and nurses for assignments and transfers in POA. Arranges emergency assignments or transfers of above personnel to ships. Maintains records of assignments and transfers of all MC, DC, NC, and officers in

Develops Hospital Corps personnel plans. Procures, assigns and distributes Hospital Corps officer and enlisted personnel in the Pacific Fleet and Pacific Ocean Areas. Administers complement control of Medical Department personnel. Acts on all matters relating to Hospital Corps personnel except those involving policy. Maintains records needed to accomplish above.

Develops plans for medical facilities POA, initiates their procurement, provides for their maintenance and recommends their expansion or reduction. Correlates and applies data of logistic significance prepared by the medical supply and sanitation sections. Coordinates agencies required for medical logistic support of the fleet and POA bases. Maintains liaison with Cinepac and FMF. Develops plans and policies on roll-up of medical activities.

Screens & validates requisitions. Prepares requisitions for special outfitting of ships in POA. Records inventories and issue rates of medical storehouses, medical barges, and medical stores issue ships. Prepares block load & special requisitions of the automatic supply system. Corrects shortages on requisitions filled on the West Coast. Estimates tonnage requirements of requisitions. Prepares monthly requests for tonnage allocations. Coordinates bookings from NMSD Pearl with ComServPac shipping allocations. Expedites shipment or transfer of medical and dental materials.

Originates and disseminates notes on field & ship sanitation. Reviews and recommends action on sanitary reports from ServFor ships. Determines and advises re requirements sanitation personnel, new sanitation items and outfitting allowances. Recommends stock levels. Screens requisitions. Consults with FMO and C&S section of AMF. Maintains liaison with Cinepac.

Publishes monthly professional and administrative data of special interest to Medical, Dental, Hospital, and Nurse Corps personnel.

Reviews and analyses POA personnel and material requirements related to maintenance of naval standards of dental treatment. Prepares detailed plans, recommendations and directives re establishment, modification and disestablishment of dental facilities in accordance with CincPac/POA directives. Screens dental requisitions. Correlates and summarises suggestions & recommendations on dental matters from ships & stations in POA. Coordinates activities of Dental Field Units, ComServPac. Develops plans and policies on roll-up of dental activities. Inspects ServFor vessels with dental facilities re their adequacy, maintenance, and operation. Maintains liaison with Cinepac.

Inspects ServFor vessels re adequacy, maintenance, and operation of their medical facilities.

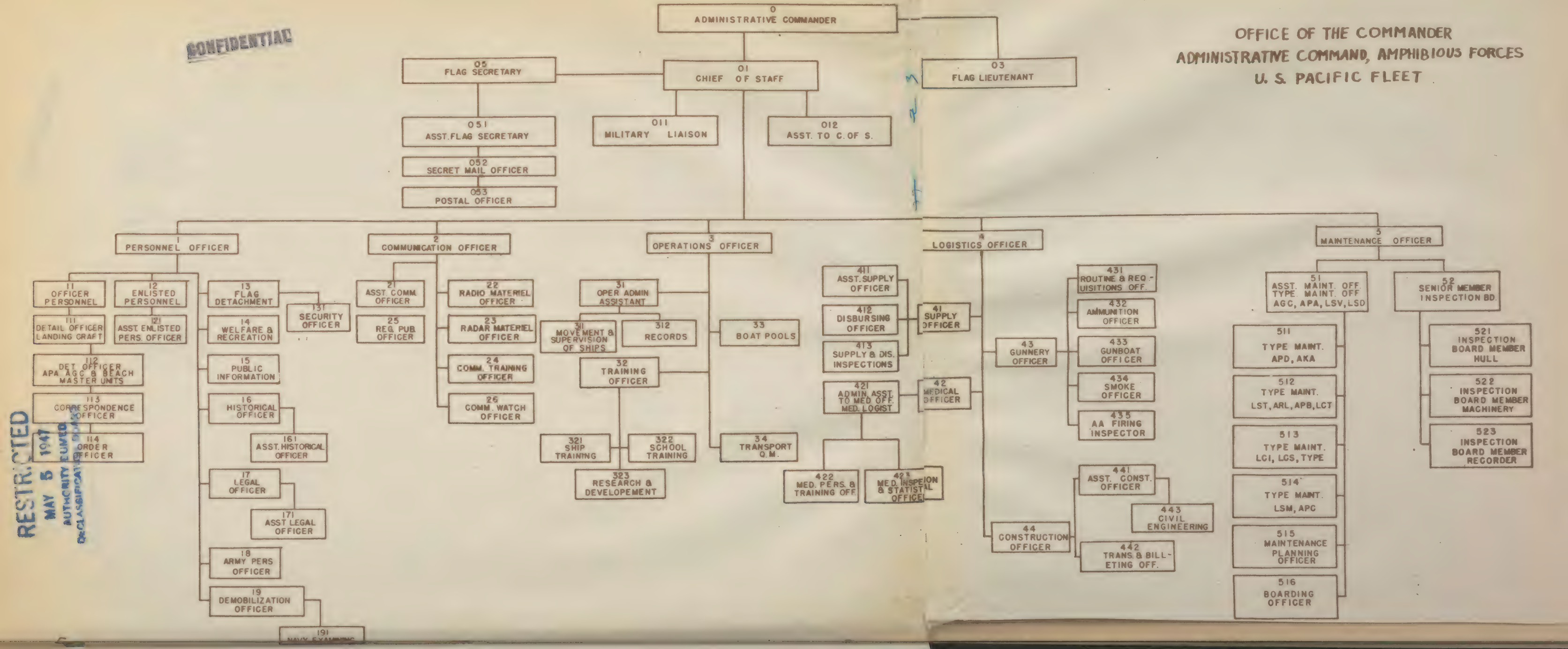
Develops medical & dental increments of ServFor operational plans.

NOTE-: This is a schematic representation of the functional organization only. It reflects personnel requirements under wartime conditions but not under peacetime circumstances. Currently certain sections are grouped for economy of personnel, each group the responsibility of one officer as follows:

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ADMINISTRATIVE COMMAND, AMPHIBIOUS FORCES
U. S. PACIFIC FLEET



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REAR ECHELON - TRAINING
SIXTH AMPHIBIOUS FORCE, ATLANTIC FLEET

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NAVY FORCE SURGEON — coordination with — ARMY FORCE SURGEON

- Personnel
  Supplies
  Correspondence
- Administrative Detachment (Basic medical facilities.)
- Landing Equipment Depot. (Basic medical facilities.)

TRAINING

- Medical preparation of vessels of the force for operations.

AMPHIBIOUS TRAINING BASES

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Little Creek
- First aid to boat crews.
- Training, supplying and equipping landing craft.
- Basic medical facilities

Fort Pierce
- Field training of medical components of beach parties.
- Basic medical facilities.

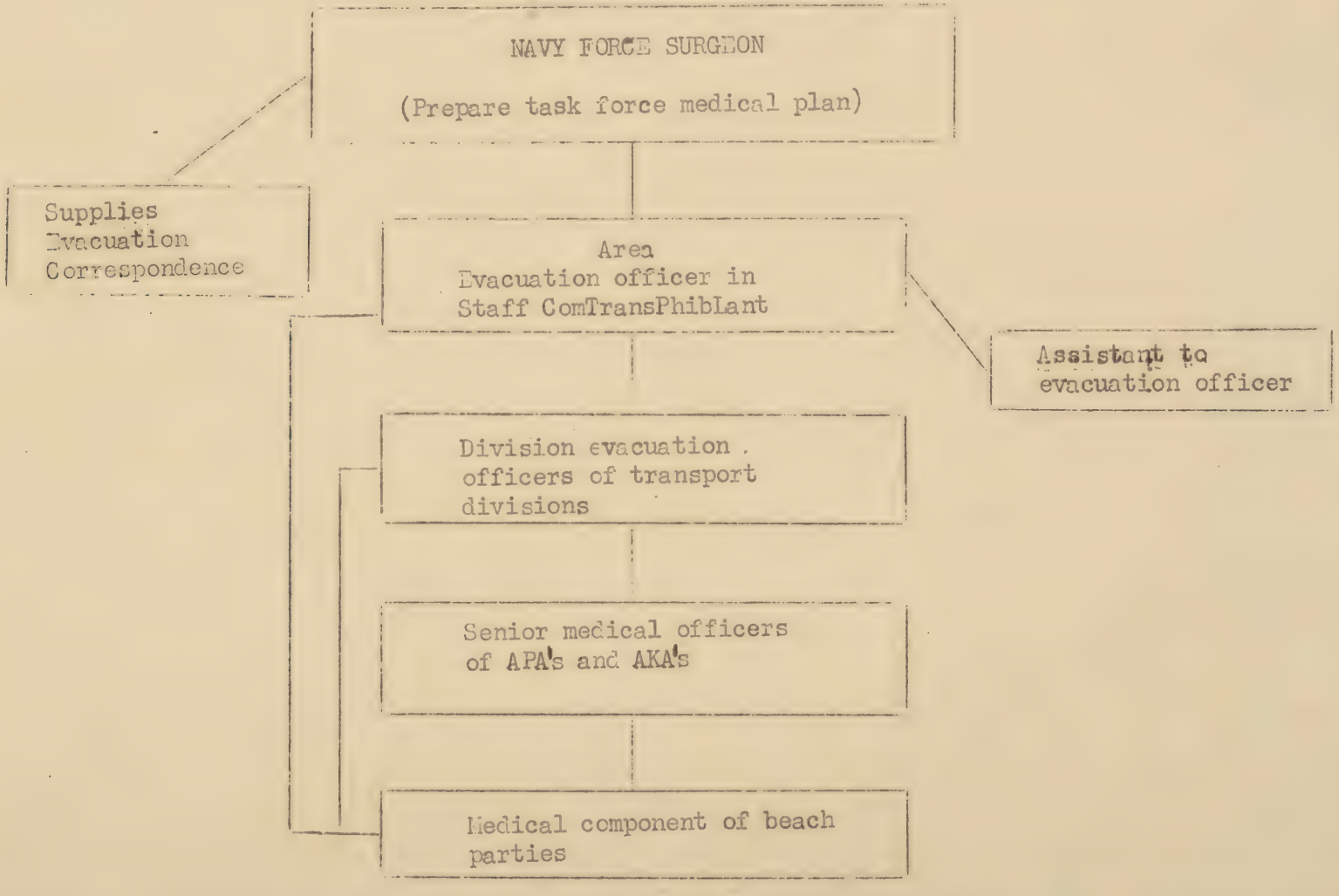
Solomons
- Special training for landing craft officer personnel
- Landing exercises with transports.
- Basic medical facilities.

Bradford
- Medical storehouse.
- Beach parties.
- Staging area.
- Basic medical facilities.

(Source: Memeographed copy of ltr. from Commander, Sixth Amphib Force to Chief, BuMed, FE25/A9, Serial: 0055, dated 22 Nov. 1943.)

FORWARD ECHELON - OPERATIONS

SIXTH AMPHIBIOUS FORCE, ATLANTIC FLEET



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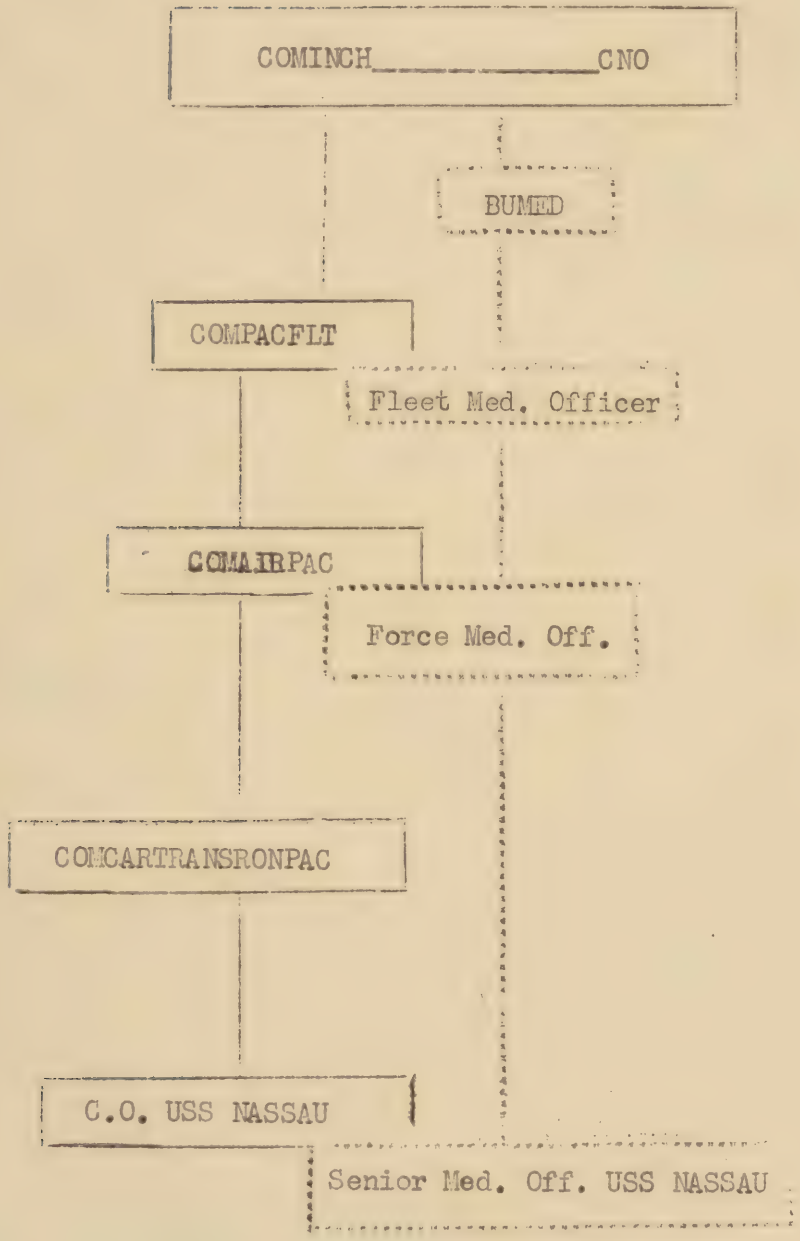
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(Source: mimeographed copy of ltr. from Commander, Sixth Amphib Force to Chief, BuMed, FE25/A9, serial: 0055, dated 22 Nov. 1943.)

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Administrative and operational relationships of the USS NASSAU (CVE 16)

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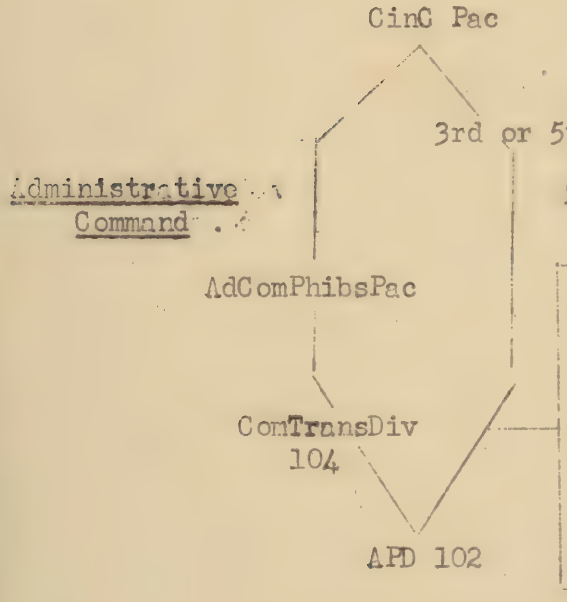
(Source: Cumulative historical report.)

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USS REDNOUR (APD 102)

"Immediately upon being commissioned this ship was placed under ComTransDiv (104), and has remained under that command. However, it has never operated with the division but has always been on independent duty. From its commissioning on 30 December 1944 until its transfer to the Pacific on 3 March 1945, this ship was under COTLant. From 3 March 1945 to 25 March 1945, the ship was immediately under COTCPac. From the latter date until the end of the war, the ship was always under the administrative command of AdComPhibsPac. However, as the following table illustrate, the ship was at various times under the immediate command of several different task groups or units."

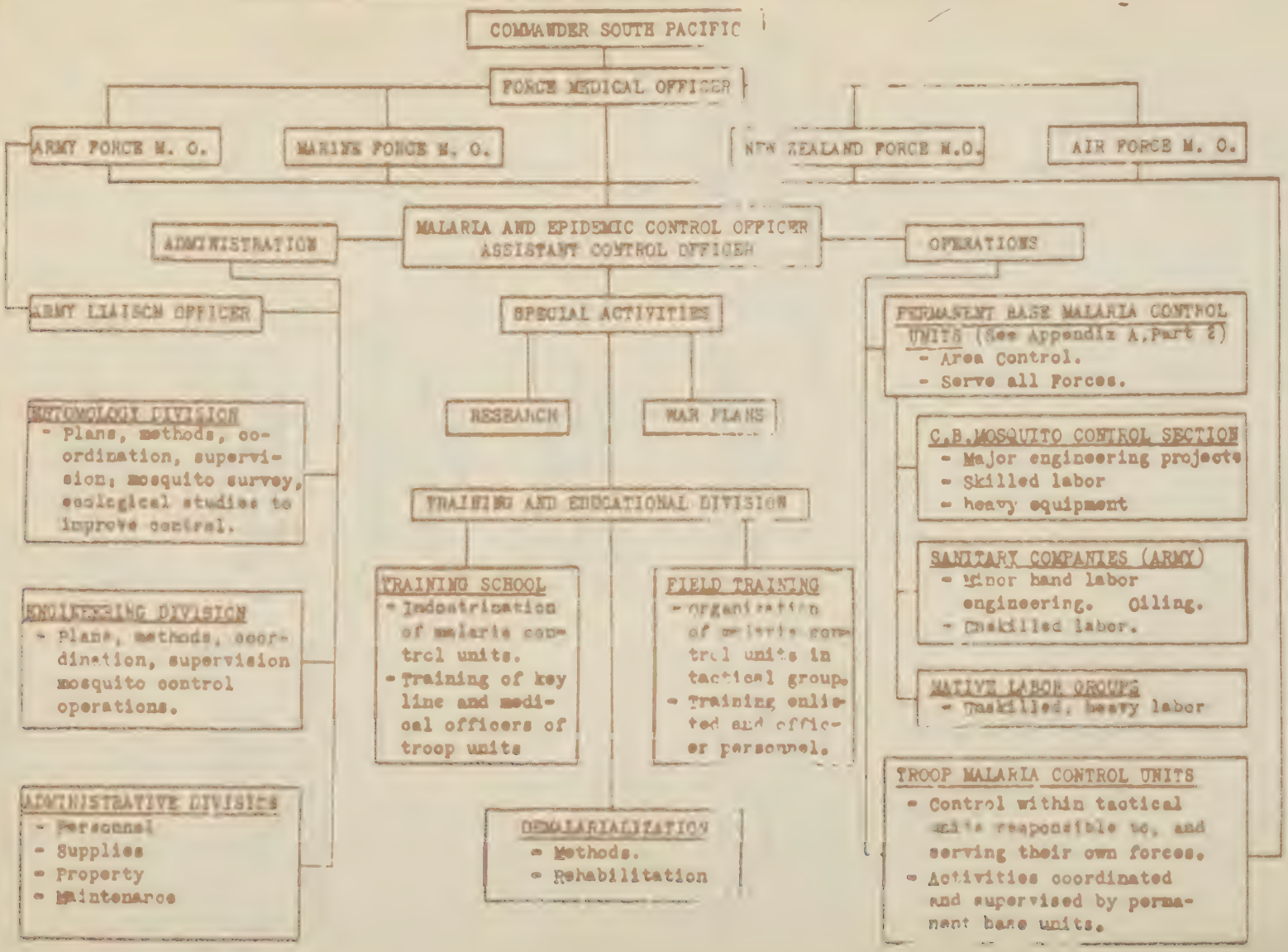


CTF 16	4-8-45	-	4-16-45
CTG 96.3	4-17-45	-	4-22-45
CTU 94.6.2	4-23-45	-	4-26-45
CTG 51.5	4-27-45	-	5-17-45
CTU 94.18.17	5-18-45	-	5-19-45
CTG 51.5	5-20-45	-	5-27-45
CTG 31.5	5-28-45	-	6-13-45
TU 31.29.8	6-14-45	-	6-28-45
AdComPhibsPac	6-29-45		

(Source: Cumulative history report.)

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GENERAL ORGANIZATION PLAN - MALARIA AND EPIDEMIC CONTROL SOUTH PACIFIC

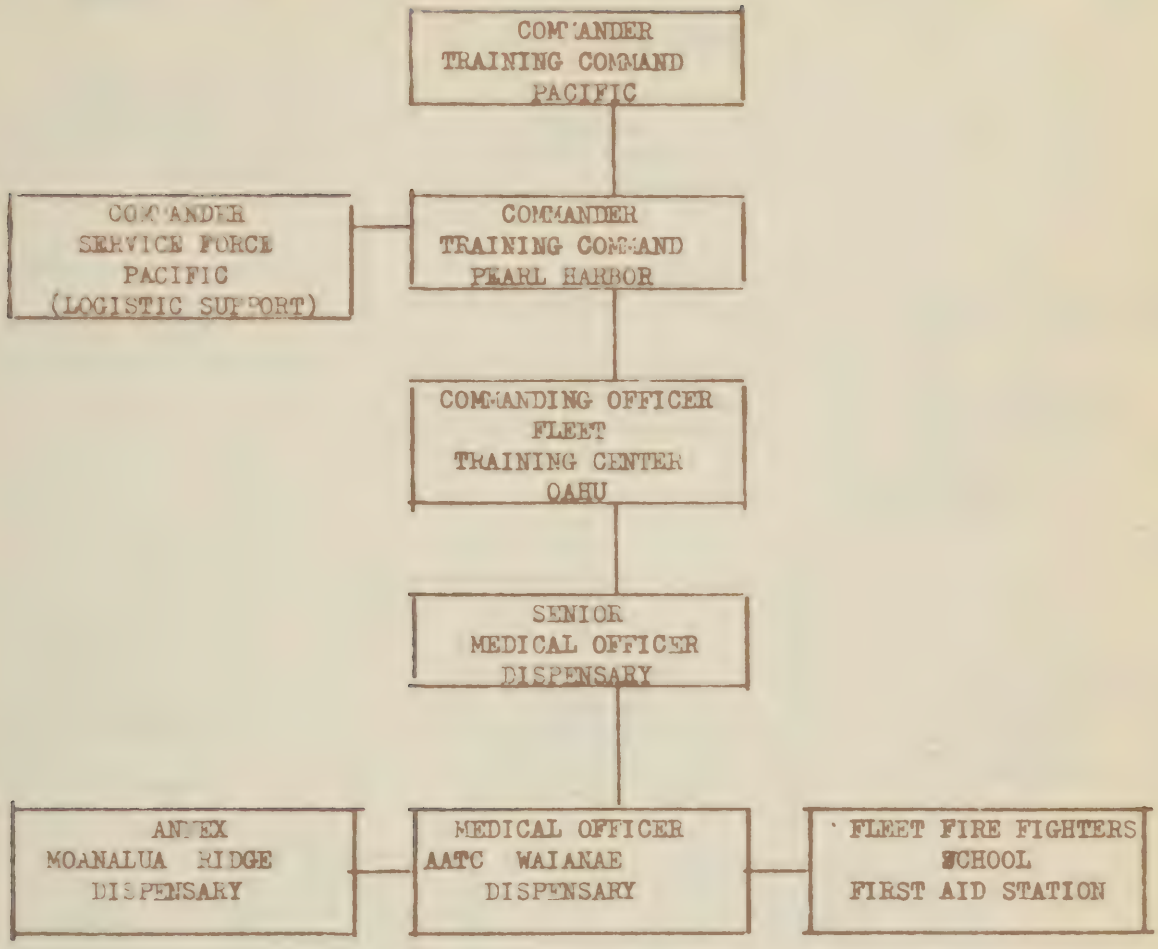


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ORGANIZATION:



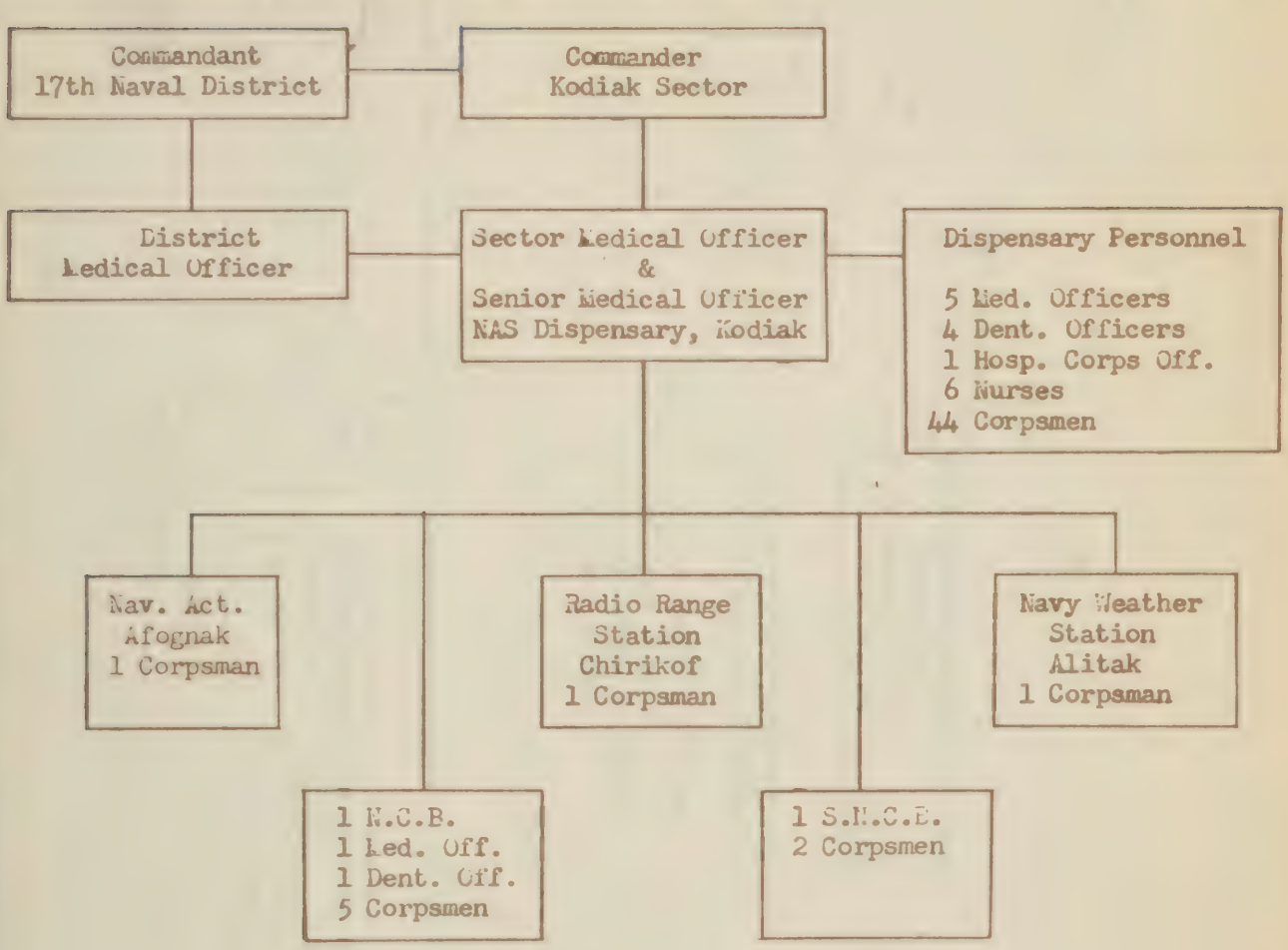
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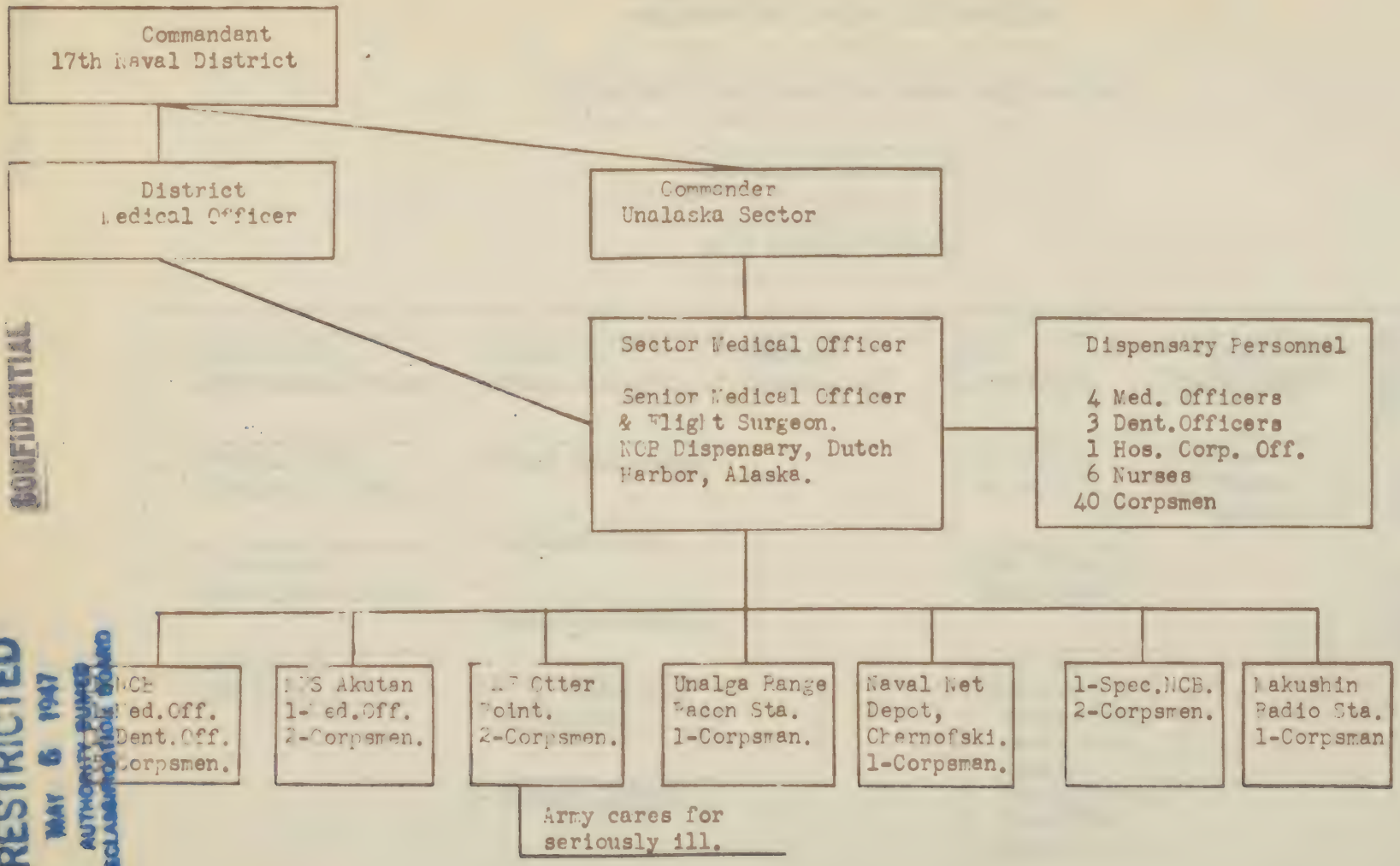
NAVY MEDICAL DEPARTMENT ORGANIZATION

KODIAK SECTOR

AT NORMAL OPERATIONS



NAVY MEDICAL DEPARTMENT ORGANIZATION, UNALASKA SUB-SECTOR, AT NORMAL OPERATION.



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ORGANIZATION CHART OF MEDICAL ACTIVITIES, NAVY 3002

COMMANDER PHILIPPINE SEA FRONTIER

COMMANDANT NAVAL OPERATING BASE, MANILA-SUBIC

COMMANDER NAVAL BASE

BASE MEDICAL OFFICER

- Dispensary Receiving Station
- Medical Unit Staging & Disch.
- Dispensary Naval Supp. Depot
- Dispensary NCB Units
- Preventive Medical Officer
  - Base Sanitation
  - Epidemiology
  - Malaria Control
  - V.D. Education & Control
  - Rodent Control
- Medical Storekeeper
- Base Dispensary
  - Sub. Disp. S. B. U.
  - Sub. Disp. Marine Camp
  - First Aid Stations
    - Grande Is., Small Boat Repair, Com.Off.Mess, Fleet Rec. Center
- Base Dental Off.
  - Fleet Dental Clinic
- Civilian Affairs Med. Off.
  - Civilian Hospital
  - Civilian Public Health

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U.S. NAVAL OPERATING BASE MEDICAL DEPARTMENT IN RELATION TO CHAIN OF COMMAND

U.S. EIGHTH FLEET

COMMANDANT, N.O.B., NAVY 157

FLEET MED OFFICER

EXECUTIVE OFFICER

CAPTAIN OF THE YARD
(Reports of accidents and injuries.
Transfers and transportation of personnel.
Shore patrol contact.
Medical inspections of barracks and mess halls.
Prophylaxis stations.)

PORT DIRECTOR
Medical and sanitation information to ships.)

REPAIR OFFICE
(Medical service to ships in dry dock.)

PUBLIC WORKS
(Repairs and maintenance inspection by medical officers.)

MEDICAL OFFICER

MAIN DISPENSARY
Hospitalization of patients.
Laboratory control of diseases.
Sanitation and pest control.
Dental Clinic — Record Office.
X-ray service — Operating room.
Venereal disease control:
(a) Venereal disease clinic.
(b) Prophylaxis stations.

PORT DISPENSARY
Base and ships sick call.
Inoculations..First-aid station.
Ambulance service.
R.P.A. Night Vision Tests.

Medical and dental care and hospitalization of all Naval Operating Base and ships personnel.

OPERATIONS
(Ambulance service to incoming ships.)

HARBOR DEFENSE
(Medical preparation for gas attacks.)

ORDINANCE
(Dressing and prophylaxis stations at Naval Ammunition Depot.)

COMMUNICATIONS
(Incoming and outgoing messages.)

CIVILIAN EMPLOYMENT
(Galley, Scullery, and cleaning help obtained.)

SUPPLY OFFICE
(Sanitation & pest control. Food and stores inspections Ships service, food and stores obtained.)

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ORGANIZATION

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ARMY ISLAND COMMAND. A.P.O. #244.
(Changed to Navy #3245 Command 15 May.)

(Relieved by Navy Captain, 13 June.)

DEPUTY MILITARY GOVERNMENT OFFICER. Army Colonel.

ISLAND MEDICAL OFFICER Army Colonel.

(Changed to Navy Captain, 15 May.)

PUBLIC WORKS | SUPPLY FINANCE | LEGAL | TRANSPORTATION | AGRICULTURE | PUBLIC SAFETY INTELLIGENCE | EDUCATION WELFARE | ECONOMICS HANDICRAFT | PUBLIC HEALTH

MAIN DISPENSARY "MILITARY PERSONNEL"
Discontinued 5 March

DENTAL DEPARTMENT

LEPROSARIUM

CHARAN KANOA CLINIC

SANITATION

JAPANESE DISPENSARY

DENTAL DEPARTMENT

JAPANESE ORPHANAGE

Supervision assumed by Jap Area Commander (5 August).

GARBAGE AND TRASH DISPOSAL | INSTALLATION AND RELOCATION OF HEADS | DAILY SPRAYING OF HEADS | MOSQUITO CONTROL | RODENT CONTROL | DRAINAGE SUPERVISION | BURIAL OF DEAD

Assumed by First Lieutenant 2 June

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BY NARS, DATE MAY 6 1977

THE MISSION OF THE PUBLIC HEALTH DEPARTMENT* HAS BEEN TO RENDER MEDICAL CARE TO THE CIVILIANS SO THAT:

1) HUMANITARIAN PRINCIPLES OF INTERNATIONAL LAW WOULD BE MET.
2) CONTAGION AND INFECTION WOULD BE CONTROLLED SO THAT CIVILIANS SHOULD NOT THEREBY CONSTITUTE A THREAT TO OUR OWN PERSONNEL.
3) CIVILIAN HEALTH WOULD BE SUCH THAT THEY COULD BE USED AS LABORERS, CLERKS, ARTIFICERS, DOMESTIC AND HOSPITAL AIDS.

* (AN ACCESSORY MISSION HAS BEEN THE MEDICAL CARE OF OUR MILITARY PERSONNEL CREW.)

(Source: Cumulative history report of the Medical Officer in Command, U.S.N. Military Government Hospital #202.)

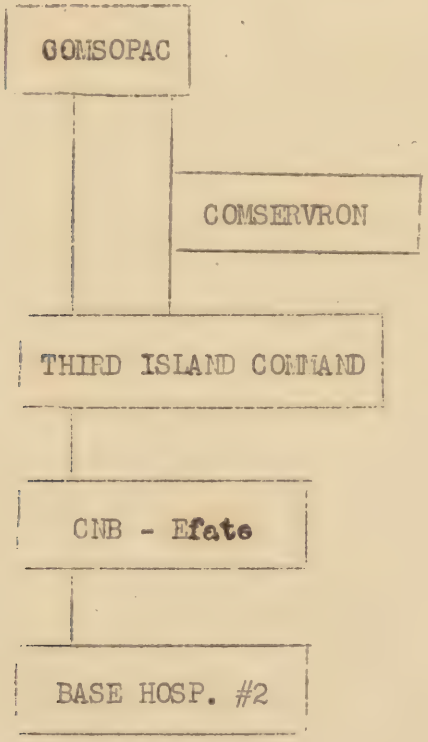
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O-R-G-A-N-I-Z-A-T-I-O-N

The basic organization of Base Hospital # 2 since its inception has been that of a standard Naval Hospital.

The hospital's position in the Naval chain of command has varied according to its location. While at its first location (Efate), its command chain was as follows:

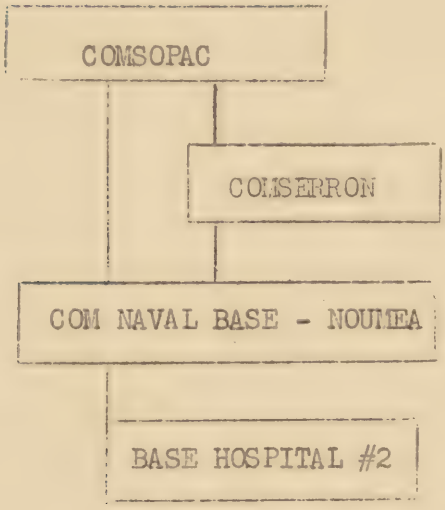
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(Source: Cumulative historical report.)

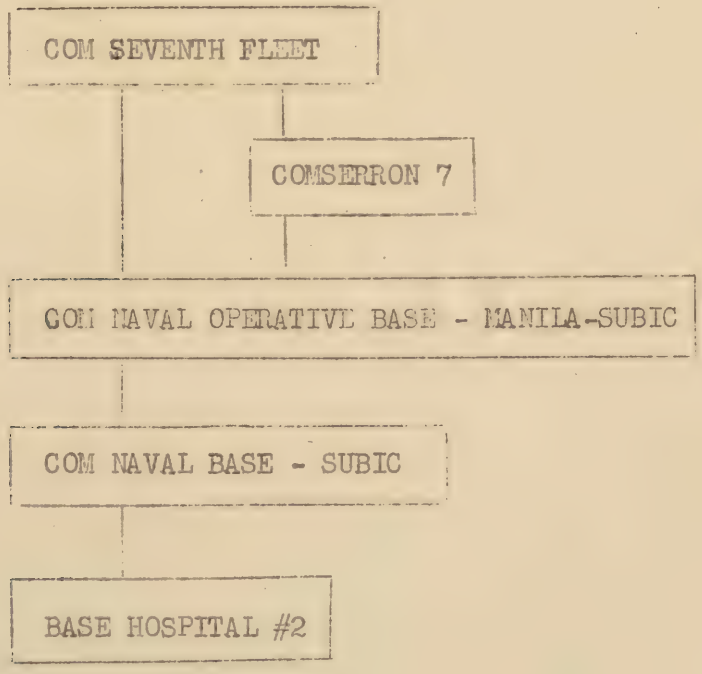
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When it moved to Noumea, its command chain was as follows:



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When the hospital moved to Subic Bay, it was transferred to the jurisdiction of the Seventh Fleet and its command chain was as follows:

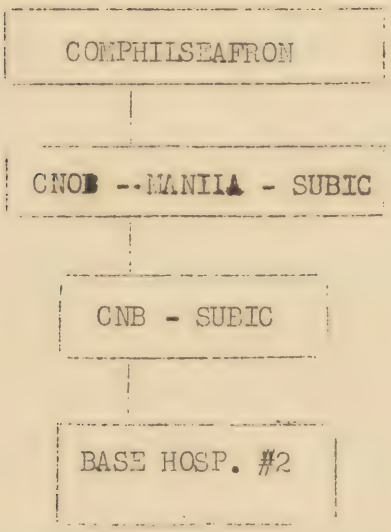


(Source: Cumulative historical report.)

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When ComPhilSeaFron took over this area from Com. Seventh Fleet, the hospital chain of command was changed to its present one:

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(Source: Cumulative historical report.)

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CHAPTER XIV

MEDICAL INSTALLATIONS IN THE PACIFIC

Section 1. Introduction

This chapter contains three sections which describe the organization and operation of shore-based facilities of the Navy Medical Department during the Pacific war. Section 2, and section 3 are about Navy hospitals that operated in the Pacific. Section 4 is devoted to Navy Medical Department shore facilities, other than hospitals, which cared for the sick and injured.

The first part (section 2) of the account of Navy hospitals in the Pacific describes the group of hospitals located in the vicinity of Pearl Harbor. This group included hospitals of different types; because of their singular role in the Pacific war and because their services were determined more by their geographical location than their type, they were treated together as a special topic. Section 3 is primarily a treatment of Navy hospitals according to type. In this section, mobile, fleet, base, and special augmented hospitals are subjects for discussion. The story of the establishment and operation of the mobile, fleet, and base hospitals is told chronologically; that is, year by year. The last part of section 3 is a brief account of the experimental use of special augmented hospitals at Okinawa. The last subdivision of this chapter, section 4, tells the story of Navy dispensaries in the Pacific war. The many and varied shore-based Medical Department facilities for caring

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for the sick and injured are discussed in relation to the higher levels of command under which they operated and in relation to the types of Navy or Marine Corps activities or organizations which they served primarily.

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Pearl Harbor Hospitals, 1942-1945

When the War engulfed Pearl Harbor on 7 December 1941, there was only one naval hospital in operation.[1] On the scene, however, was Mobile Hospital Number 2, which quickly improvised facilities and supplies and treated casualties from the attack. During the first year of the War, the Mobile Hospital and the U. S. Naval Hospital in the Navy Yard at Pearl Harbor bore the brunt of hospitalization not only for the Pearl Harbor area but also for the entire Central Pacific.

A permanent hospital of modern design, under construction at Aiea Heights, was not ready to receive patients until 12 November 1942. When the Aiea Heights hospital was opened, it afforded great relief to the overstrained resources of the Navy Yard hospital and the Mobile Hospital. Although the hospital at Aiea Heights was planned as a replacement for the one at the Navy Yard, which was too crowded and too dangerously close to military installations, the great needs of war required that the hospital in the Navy Yard continue in operation indefinitely. Throughout 1942 and 1943, therefore, the hospital in the Navy Yard continued to receive and treat patients. Not until 21 March 1944, were the equipment, staff,

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1. No attempt is made to cite the sources of all statements made in this chapter. The reports used, comparatively small in number, are listed in the bibliography. Consultation of this bibliography will make most of the sources of information fairly obvious.

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and patients of the Navy Yard hospital transplanted to the new location at Moanaloa.

The Mobile Hospital continued to operate throughout 1942. Decommissioned in 1943, the equipment and supplies became the property of the U. S. Naval Hospital at Aiea Heights, while the buildings were utilized by Base Hospital Number 8, another temporary, transportable facility that was commissioned 1 November 1943.

Throughout the War, therefore, there were at all times at least two separate and distinct hospital units in the Pearl Harbor area, and during most of the War there were three:

> From the outbreak of war until 12 November 1942: (1) the U. S. Naval Hospital in the Pearl Harbor Navy Yard; (2) Mobile Hospital Number 2.
>
> From 12 November 1942, until 1 November 1943: (1) the U. S. Naval Hospital in the Pearl Harbor Navy Yard; (2) Mobile Hospital Number 2; (3) U. S. Naval Hospital, Aiea Heights.
>
> From 1 November 1943, until 21 March 1944: (1) U. S. Naval Hospital, Navy Yard; (2) U. S. Naval Hospital, Aiea Heights; (3) Base Hospital Number 8.
>
> From 21 March 1944, until the close of the War: (1) U. S. Naval Hospital, Moanaloa; (2) U. S. Naval Hospital, Aiea Heights; (3) Base Hospital Number 8.

The hospital at Aiea Heights was the only permanent hospital in the group of Pearl Harbor hospitals. The hospital at the Navy Yard was housed in permanent buildings until it moved to Moanaloa, where it occupied prefabricated buildings similar to those used by transportable base hospitals. Mobile Base Hospital

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Numbers 2 and Base Hospital Number 8, of course, used prefabricated, transportable buildings and were, therefore, even less stationary than the temporary, wooden structures erected at many of the new hospitals in the United States.

Hospital Units, 1942-1943

In 1942 the main hospital facility was the old U. S. Naval Hospital in the Pearl Harbor Navy Yard. There was a great increase in the number of patients treated in the hospital, but there was not a great expansion in ward buildings and other physical facilities to take care of the load. Plans called for maintenance of the status quo at the Navy Yard hospital, since a much larger and more modern hospital was under construction at Aiea Heights. The increased number of patients at the Navy Yard hospital, therefore, could be cared for only by moving the beds closer together, by placing them on the porticoes, and by using tents for ambulatory patients.

During the first year of the War, the patients coming to the Pearl Harbor hospitals were divided between the Navy Yard hospital and the Mobile Hospital on the basis of their origin; that is, the Navy Yard hospital took care of patients from the shore installations in the Pearl Harbor area, while the Mobile Hospital took patients from ships of the fleet that docked at Pearl.

From 12 November 1942, until 18 August 1943, the naval hospitals at the Navy Yard and at Aiea Heights were administered

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jointly by the same medical officer in command. These two hospitals, while under the same command in 1943--from 1 January to 31 August--had an average duty personnel strength of 87 officers, 700 enlisted men, and 111 nurses. During the same eight months of 1943, the patients in the two hospitals numbered 7,137.[2]

During the last third of 1943 (1 September 1943-31 December 1943) the hospital in the Navy Yard, with a staff which averaged about 41 officers, 331 enlisted men, and 54 nurses, treated approximately 2,269 patients. During the same period (last third of 1943) the new hospital at Aiea Heights had a staff which averaged 60 officers, 598 enlisted men, and 76 nurses, while the number of patients totaled 6,226. Thus, during the last third of 1943, the new hospital at Aiea Heights served more than twice as many patients as the older hospital in the Navy Yard.[3]

Base Hospital Number 8, which was commissioned on 1 November 1943, did not receive patients regularly during 1943. The average strength of the duty personnel during the period from the commissioning date until the close of the year was 22 officers, 204 enlisted men of the Hospital Corps, and 84 enlisted men of other ratings. There were no nurses on the staff of Base Hospital Number 8. A total of 71 patients, of which 11 were enlisted men

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2. Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1943.
3. Ibid.

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from the staff, were admitted to the hospital in 1943.[4]

Hospital Units, 1943-1945

In 1944 the number of patients cared for by the hospital at Aiea Heights swelled: 38,203 enlisted men, 3,422 officers, and 96 nurses were admitted during the year. The staff during the year, of course, had a similar expansion. The average strength of the staff during the year was 111 officers, 1,426 enlisted men, and 254 nurses. The Pearl Harbor hospital--at the Navy Yard until 21 March when the staff and patients were transferred to Moanaloa-- continued to expand its bed capacity, but not nearly so rapidly as did the Aiea Heights hospital. The Pearl Harbor (Navy Yard-Moanaloa) hospital treated 9,908 patients; the average strength of duty personnel for the year was 49 officers, 681 enlisted men, and 108 nurses. The third hospital unit, Base Hospital Number 8, treated considerably fewer patients than the Aiea Heights hospital but somewhat more than the Pearl Harbor (Navy Yard-Moanaloa) hospital. Base Hospital Number 8 treated 11,125 patients and had an average of 54 officers, 582 enlisted men, and 67 nurses on the staff.[5]

Battle Casualties

Except for patients who had been injured in the Pearl Harbor attack, battle casualties received during 1942 did not

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4. Annual Sanitary Report from Base Hospital Number 8 for 1943.
5. Annual Sanitary Reports.

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constitute a large part of the patient load in the Navy Yard hospital and Mobile Hospital Number 2. In 1943, following the landings and campaigns in the Solomons and the Gilberts, battle casualties began to arrive at Pearl Harbor in considerable numbers. On 21 July 1943, 248 patients--the first group of casualties from the Southwest Pacific--arrived at the Pearl Harbor (Navy Yard) hospital. In December 1943, 89 survivors of the USS LISCOMBE BAY and 418 casualties from the battle of Tarawa were received by the Pearl Harbor (Navy Yard) hospital. When the year closed, the hospital at Aiea Heights had 1,709 patients, many of whom were from the invasion of the Gilbert Islands; 1,358 had been admitted from Tarawa.[6]

A large portion of the casualties at Pearl Harbor in 1943 were malaria cases. Sixty-four patients suffering from malaria were treated in the Navy Yard hospital in 1943; 61 had the benign tertian form. These patients had acquired the disease in an endemic area of the Southwest Pacific. There were 18 cases of filariasis admitted to the Pearl Harbor (Navy Yard) hospital in 1943. All were Marines who had served in an endemic area of the Southwest Pacific.[7]

In 1943, the hospital at Aiea Heights underwent a tremendous

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6. Cumulative History Report from U. S. Naval Hospital, Pearl Harbor, Historical Data Supplement to Annual Sanitary Reports from U. S. Naval Hospital, Pearl Harbor, and U. S. Naval Hospital, Aiea Heights, for 1943 and 1944.
7. Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1943.

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growth. The number of newly constructed wards, fortunately, was increased at the same time that casualties in large numbers arrived from the Solomons, the Gilberts, and the Marshalls. The drafts of incoming patients, numbering in the hundreds for each draft, were usually admitted within a few days.[8]

In 1944 the number of casualties received at the Pearl Harbor hospitals increased further. The Aiea Heights hospital admitted 5,256 men from Saipan and 2,848 from Guam and Tinian. Between 25 June 1944, and 14 September 1944, a total of 7,667 patients, of whom 2,255 were transported to Pearl Harbor by air, were admitted to the Aiea Heights hospital. The greatest number of patients admitted on any one day was 1,169 on 3 July 1944. The Pearl Harbor (Navy Yard-Moanaloa) hospital also received numerous casualties from the Marianas campaign. The first casualties from Saipan were 24 stretcher cases who arrived by air on 25 June 1944. On 11 July, 112 casualties who had been wounded on D-day at Saipan were admitted to the Pearl Harbor (Moanaloa) hospital. The next day, the Pearl Harbor (Moanaloa) hospital admitted from the USS TERROR and USS FREMONT 54 casualties, most of whom suffered from nervous disorders. The greatest influx of casualties from accidental causes occurred on 21 May 1944, when several ships loaded with ammunition exploded in the harbor. Medical officers and ambulances were sent immediately

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8. Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Aiea Heights, for 1943.

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to the scene and transported patients back to the hospitals at Aiea Heights and Moanaloa.[9]

In 1944, 145 patients with malaria, an increase of more than 100 percent over the previous year, were treated at the Pearl Harbor (Moanaloa) hospital. All of these cases came from theaters of war in which the disease was endemic. The admissions to the hospital for filariasis numbered 79, or four times as many as the previous year. All the men who had this disease were from the Marine Corps or from the Hospital Corps attached to Marine Corps units in the combat areas.[10]

During 1944 acne became a serious medical problem in the combat areas. Infections, pain, and skin irritation on the back, shoulders, chest, and inner sides of the legs increased with sweating, lack of facilities to care for the skin and clothing, and poor diet. In some cases severe infection took on the proportions of pyodermia, and in many cases it was impossible for the infected men to carry packs on their backs because of the severe pain. In the Pearl Harbor hospitals these cases cleared moderately; some of the severe cases, however, had to be evacuated to the mainland for further disposition.[11]

In June and August of 1944, about 100 Japanese-Korean prisoners were received at the Pearl Harbor (Moanaloa) hospital. These

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9. Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Aiea Heights, and U. S. Naval Hospital, Pearl Harbor, for 1944.

10. Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1944.

11. Ibid.

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men were emaciated, dehydrated, and dirty, and a majority were infected with intestinal parasites. Their injuries were mostly multiple gunshot wounds of extremities with infected compound fractures. Intravenous injection of fluids, cleaning of the wounds, and application of casts produced results described as "amazing."[12]

With the removal of the battle area thousands of miles from Pearl Harbor, fever casualties were being admitted to the Aiea Heights hospital at the close of 1944. Nevertheless, the total number of patients continued to increase because of the reduced activity of the Pearl Harbor (Moanoloa) hospital and the increase of personnel in the Hawaiian Islands. The greatest hospital load at Aiea Heights in 1944 was on 27 December, when 5,168 were listed on the census.[13]

Diseases

There were no major epidemics in the Pearl Harbor area in 1942. In the winter of 1942-1943, respiratory infections, especially the atypical variety of bronchopneumonia, accounted for a considerable number of admissions. During the summer of 1943, there was an epidemic of dengue fever among the civilian population, but the number of cases among naval personnel admitted to the Navy Yard hospital remained small. Fungus infection of the skin was encountered frequently in 1943 and 1944. Because of the warm, damp climate in the Pearl Harbor area, the

12. Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1944.

13. Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Aiea Heights, for 1944.

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presence of epidermophytid, and the lack of personal care of the skin of the feet, the incidence of fungus infection of the feet was high among the Navy and Marine Corps personnel. The Pearl Harbor (Moanaloa) hospital admitted 258 cases of fungus infection in 1944. A major outbreak of food poisoning that occurred in 1943 at the Submarine Base, Pearl Harbor, was responsible for 451 admissions at Aiea Heights. In March 1944, Base Hospital Number 8 received a group of approximately 100 cases of bacillary dysentery from the personnel of a signle ship.[14]

Hospital Personnel

In 1942 and 1943 the number of medical officers in the Navy Yard, Aiea Heights, and mobile hospitals was sufficiently large to care for any emergency that might arise, although several categories of specialists, i.e., psychiatrists and dermatologists, were needed at Aiea Heights. In 1944, medical officer personnel at the Pearl Harbor hospitals were sufficient except in the department of medicine. Aiea Heights, in 1944, had difficulty in maintaining the number of surgeons authorized because of the practice of filling emergency vacancies in the fleet and shore establishments. Twenty-two interns were added to the Aiea Heights staff in 1944, but they provided little relief, since they had to be supervised carefully by the senior officers of the hospital.[15]

Nurses served at both the Pearl Harbor (Navy Yard and Aiea

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14. Annual Sanitary Reports.

15. Ibid.

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Heights) hospitals, but not at Mobile Hospital Number 2 or Base Hospital Number 8. Throughout the War, the complement of nurses was satisfactory. By 1943 the hospitals were receiving many nurses who were inexperienced and untrained in Navy routine.[16]

In the first two years of the War there was some difficulty in maintaining a sufficient number of hospital corpsmen. During the first five months of 1942, the number of corpsmen at the Pearl Harbor (Navy yard) hospital was inadequate; but after the gradual filling of an increased complement authorized May 1942, there were enough corpsmen to care for the maximum capacity of patients. Mobile Hospital Number 2 would have had a sufficiently large complement in 1942 if the men had been better trained and more experienced. In 1944 the Pearl Harbor hospital was overstaffed for a short period; but after the transfer to the new location at Moanaloa, the excess was eliminated. At Aiea Heights, where the number of corpsmen was too small during the early months of 1943, the gradual filling of an increased allowance authorized in November and the assignment of men with artificer and commissary ratings to the hospital resulted in a suffient number of corpsmen to care for the maximum number of patients. The need for more corpsmen in the wards at Aiea Heights was partially met also by attaching a construction battalion maintenance unit to the hospital. By assigning men from this unit to details such as commissary, grounds,

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16. Ibid.

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transportation, and maintenance, many corpsmen were relieved for duty on the wards.[17]

Civilian workers were employed at the Pearl Harbor and Aiea Heights hospitals. Civilians were assigned to jobs in administration, laundry, transportation, maintenance, commissary, and nurses' quarters. In 1942 the authorized civilian complement of the two hospitals was 261 employees of various ratings. Of the number authorized, there were only 167 persons actually on the pay roll. Throughout the war, the actual number of civilian employees continued to fall short of the authorized complement. In 1944, the Aiea Heights hospital was able to employ and retain only about 50 percent of the authorized complement. Shortages of workers for the commissary and shortages of skilled workers for maintenance were the most troublesome. The failure to fill these civilian jobs necessitated the practice, admittedly an undesirable one, of using hospital corpsmen for jobs such as care of the grounds, shop work, scullery duties, and other work for which they were not trained.[18]

The U. S. Naval Hospitals at Pearl Harbor furnished medical officers and hospital corpsmen for outlying islands and bases, filled emergency vacancies at sea, and provided a larger number of hospital corpsmen for ships and stations in the Pacific area. These transfers

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17. Ibid.

18. Ibid.

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caused a fairly large turnover of medical officer and corpsman personnel and created temporary shortages.[19]

Supplies

Throughout the war, the hospitals in the Pearl Harbor area were well supplied with medicines, drugs, and hospital supplies. During the first year of the War, there was no appreciable deterioration in the quality of supplies, and delivery was fairly prompt. In 1942, orders were usually in Pearl Harbor six weeks after the date of requisitions sent to San Francisco for filling; but in 1943, and later, as the demands for shipping of vital war materials to the combat areas multiplied, the delivery of items requisitioned from the mainland was somewhat slower, Delays were anticipated, however, and increasingly large quantities were requisitioned to allow for slow deliveries.[20]

In 1942 and 1943 essential drugs normally purchased in the open market by naval hospitals could still be obtained fairly easily from local dealers. Although difficulties in procuring such items from the mainland were encountered, the hospitals had to continue to make purchases of a few open-market items from dealers on the mainland.[21]

Transportation

Each year of the War, as the number of patients received

19. Ibid.
20. Ibid.
21. Ibid.

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and evacuated increased, the number of ambulances and other transportation vehicles had to be augmented. Both the limousine and field type ambulances were used by the hospitals. On smooth surfaced roads, the limousine type of ambulance was superior in performance and economy to the field type ambulance; but the field type ambulance was much more useful over rough terrain.[22]

In case of a sudden need for transportation of large numbers of casualties, the hospital had access to a motor pool which was located in the transportation department of the Navy Yard. This pool, together with other types of transportation belonging to the hospitals, assured the hospitals ample transportation facilities to take care of any emergency that might arise. In 1943, the Navy Yard hospital, when large numbers of patients were received or evacuated, occasionally had to request transportation from the Navy Yard for ambulatory patients. Base Hospital Number 8 had an ambulance boat which made regular daily trips to ships moored in the harbor, in order to pick up patients for hospitalization or consultation. Emergency trips were made by the launch upon request of the district medical officer.[23]

At Aiea Heights and the Pearl Harbor (Navy Yard-Moanaloa) hospital civilian drivers were employed during the regular working hours

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22. Ibid.

23. Ibid.

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while hospital corpsmen stood the night ambulance watches. At Mobile Hospital Number 2 and Base Hospital Number 8 hospital corpsmen served as ambulance drivers at all times.[24]

Routine transportation of the sick and injured to and from the Aiea Heights hospital in 1942 and 1943 was supervised through the office of the officer of the day; but in 1944, the transporation was placed under a Hospital Corps officer.[25] This transportation officer operated directly under the executive officer maintained constant liaison with the district medical officer. The revised arrangement enabled the hospital to work in much closer cooperation with the district medical officer when patients were received or evacuated.[26]

Reception, Admission, and Evacuation of Patients

The casualties that arrived in large numbers at Pearl Harbor in 1943 from the Solomons, the Gilberts, and the Marshalls were usually admitted within a few days. Evacuation of patients to the United States to make room for incoming patients was carried out smoothly, although the personnel officer and his staff were, at times, given no more than twelve hours' notice, and despite the frequent necessity for using temporary facilities to take care of the sudden influxes of casualties. Late in 1943, when a large number of casualties

24. Ibid.
25. Ibid.
26. Ibid.

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were admitted to the Aiea Heights Hospital, all medical cases were moved into temporary wards, some of which were not completely finished and equipped with double deck beds in order to accommodate the greatly increased number of patients when large drafts of casualties arrived at Pearl Harbor, the staff had to work extra hours in order to accomplish the task of admitting the patients in a short time. Usually, shore leave and liberty had to be cancelled, however, for no more than a day or two.[27]

In 1944, by the time that patients began to arrive by air and ship from Kwajalein and Eniwetok, a system of admissions was worked out which simplified distribution of incoming patients. The executive officer and chiefs of medicine and surgery examined the newly arrived patients and assigned them to the appropriate wards. The admission procedure was improved further when casualties from Saipan and Tinian began to arrive; every patient was tagged and a stub kept in the admission room. When the patient arrived on the ward, the tag was filled out and returned at once to the personnel officer[28] in order that an accurate record could be kept.

In order to have space and beds for the large number of casualties admitted to the Pearl Harbor hospitals, it became necessary

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27. Annual Sanitary Report and Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Aiea Heights, for 1943.

28. Annual Sanitary Report and Historical Data Supplement from U. S. Naval Hospital, Aiea Heights, for 1944.

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to evacuate to the continent patients who would require more than 60 days' hospitalization. Such patients were evacuated after shrapnel was removed, fractures reduced, or other emergency measures taken and sufficient strength had returned to permit ocean travel.[29]

A rather high proportion of the casualties brought to Pearl Harbor, during the latter part of the war, came by air. Between 1 March 1945 and 20 October 1945, 7,139 patients were brought to the Pearl Harbor (Moanaloa) hospital by air and 3,210 were evacuated from the same place during the same period. Patients evacuated by ship during this period totaled 8,606.[30]

Internal Organization

Each of the naval hospitals at Pearl Harbor followed the basic internal organization generally found in the U. S. Naval hospitals. At the head of each U. S. naval hospital and of Mobile Hospital Number 2 was a medical officer in command whose authority was analogous to the commanding officer of any other naval shore establishment. The second ranking officer of the hospitals was the executive officer who was directly above the two main branches of the hospital.

Clinical - Professional Branch

The two main branches of the hospitals were (1) the

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29. Ibid.

30. Annual Sanitary Reports.

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administrative-clerical, and (2) the clinical-professional. The administrative branch was subdivided into offices, shops, and services which dealt with matters such as personnel, maintenance, commissary, disbursing, assignment and supervision of nurses, assignment and discipline of Hospital Corps personnel, ship's service, religious activities, welfare and recreation, and educational services.

The clinical-professional branch was subdivided into two principlal departments under a chief of medicine and a chief of surgery. In addition to these basic departments, there were special departments for eye, ear, nose, and throat cases; X-ray; physiotherapy; laboratory, and dentistry. The extent to which special functions were organized into separate departments depended usually upon the size of the hospital. Generally, the larger hospitals had more separate departments for special functions. Urology, for example, constituted a separate department at Pearl Harbor and Aiea Heights, but was included in the department of surgery at Base Hospital 8. Other services organized into separate departments at the Aiea Heights and Pearl Harbor (Navy Yard-Moanaloa) hospitals were those of the chief nurse, allergy clinic, and out-patients.

The grouping of patients in the wards and the arrangment of auxiliary facilities within any one of the departments were neither fixed nor standardized. Flexibility was both desirable and necessary because of fluctuations in the various types of cases. In the medical

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departments there were usually special wards or sections designated for contagious, neuropsychiatric, acute medical, chronic medical, gastro-enterologic, dermatologic, syphilitic, general medical, cardiac, and respiratory cases, and for sick officers. Any given ward might have cases that included a combination of different types of cases. In emergencies and during epidemics, rearrangements were invariably necessary and the ward space for a disease might be expanded manifoldly temporarily. For example, an epidemic of mumps among fleet personnel in 1942 necessitated assignment of an entire ward to such cases. Throughout the War, the space for dermatological and neuropsychiatric cases was comparatively large; on the other hand, space for contagious diseases was comparatively small.[31]

The department of medicine of the Pearl Harbor (Moanaloa) hospital expanded rapidly after May 1944. During the summer and fall of 1944, the admission rate reached about 200 cases per month, and the total number of patients at one point rose to a peak of 300. In December 1944 the admission rate fell to about 150 per month. In 1944 the medical department of the Moanaloa hospital treated about 5,000 cases and rendered 3,000 consultations for outpatients.[32]

At the Pearl Harbor (Navy Yard-Moanoloa) hospital in 1944, the largest single subdivision of the medical department was the

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31. Ibid.

32. Annual Sanitary Report for 1944.

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neuropsychiatric service. Many patients admitted to the wards of the hospital medical department had chronic complaints which, unverified by physical or laboratory examination, required psychiatric consultation and observation. For example, 582 medical patients were in the Pearl Harbor (Moanaloa) hospital on 20 November 1944; of these only 60 were bed patients and of this number only 27 were running any temperature. The great majority of cases treated at the hospitals were neuroses and milder types of disorders precipitated by combat or overseas operational conditions. Among these cases, a disproportionately high number were men who had been recently inducted into the service. A majority of the patients at the Pearl Harbor hospitals were unfit for duty in the Pacific area and were evacuated to the continental United States.[33]

A great part of the work of the neuropsychiatric sections of the hospitals consisted of consultations for patients from shore stations and ships in the Hawaiian area. During the last four months of 1944 the number of consultations at the Pearl Harbor (Moanaloa) hospital averaged about 150 per month, or about the same number as were admitted for observation and care. Of all patients seen in consultation approximately two-thirds were from other wards of the hospital and one-third from other activities. During the last quarter of 1944, about half of the patients referred to the Pearl Harbor

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33. Ibid.

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(Moanaloa) hospital from other activities for neuropsychiatric consultation were found unfit for duty in the Pacific area and were evacuated without admission to the hospital. This policy of immediate evacuation reduced the number of patients actually on the wards by probably one-half.[34]

A difficult problem for the neuropsychiatric section of the Pearl Harbor (Navy Yard) hospital were the patients who were referred to the section because of their having experienced convulsive or unconscious states. The health records of these patients frequently failed to contain descriptions of the attacks. At the hospital many of these patients failed to have another attack, and abnormal clinical and laboratory findings were absent. Correct diagnosis of such cases would have been facilitated if detailed accounts of the attacks had been recorded in the health records.[35]

At the Pearl Harbor (Navy Yard-Moanaloa) hospital in 1944, another large section within the medical department was the one for acute and chronic medical cases. All types of respiratory diseases accounted for about 750 cases. Of these 210 were catarrhal fever, acute; 100 were pneumonia, primary atypical, etiology unknown; 30 were pneumonia, broncho, and 7 pneumonia, lobar. Gastro-intestinal, gall bladder, and parasitic diseases occurred next most frequent y. Arthritis, acute and chronic cases (225) followed. Cardiac conditions (17)

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34. Ibid.

35. Annual Sanitary Report from the U. S. Naval Hospital, Pearl Harbor, for 1943.

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were relatively numerous. A large group of admissions for headache proved a perplexing problem; more than 1000 cases were seen in consultation at the Pearl Harbor (Navy Yard-Moanaloa) hospital in 1944. Patients with dermatological diseases accounted for a large number of sick days because of the persistence and frequency of fungus infections and acne. In 1944, the medical department of the Moanaloa hospital treated or examined more than 10,000 persons.[36]

An allergy clinic for the Fourteenth Naval District was set up at the Pearl Harbor (Navy Yard-Moanaloa) hospital on 11 December 1944. This clinic attempted to ameliorate the condition of men who suffered from hay fever and asthma and undertook a thorough investigation of the etiology of these maladies. The allergy tests included intracutaneous injections of 20 inhalants, 40 foods, 16 airborne mold spore extracts, and at least 13 pollens. During the period 1 April 1944 - 31 December 1944, there were 2,636 visits to the allergy clinic.[37]

As the War progressed, the surgical departments of the hospitals expanded even more rapidly than the medical departments. At Aiea Heights, in 1943, the work of the surgical departments increased three fold. In January 1943, 97 major and 37 minor operations were performed. In December, 217 major and 336 minor procedures were

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36. Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1944.

37. Ibid.

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carried out. On 1 December 1943 there were 362 surgical patients in the hospital; by 13 December 1943, this number had increased to 1,119. In 1944, the Aiea Heights hospital reported 3,498 major operations and 2,971 minor operations.[38]

At Aiea Heights in 1944 the number of surgical patients declined after the successful conclusion of the Marianas campaign; but in December the total patient load became heavier because of the reduction of the number of patients admitted to other shore facilities in the Hawaiian area. On 26 December, the census of the Aiea Heights hospital reached its peak for the year.[39]

The surgical departments, like the medical departments, were subdivided into wards and sections according to types of cases. General surgery, orthopedic and traumatic surgery, septic and rectal surgery, burns, neurosurgery, and urological surgery were at one time or another, the principal sections of the Aiea Heights and Navy Yard-Moanaloa hospitals. The EENT clinic of Base Hospital Number 8 was also included in its surgical department. Auxiliary facilities such as operating rooms and centralized surgical dressing supply units were, of course, organized in the surgical departments. In 1943, care of burn cases at the Aiea Heights hospital was transferred from the medical to the surgical department. In the Navy yard hospital, in 1942, clean surgery was confined to two operating rooms. Dirty

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38. Annual Sanitary Reports.

39. Annual Sanitary Report from U. S . Naval Hospital, Aiea Heights, for 1944.

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surgery, including infected lesions and rectal and adjacent surgical conditions, was confined to a ward apart from clean surgery.[40]

At the Pearl Harbor (Navy Yard-Moanaloa) hospital there were six emergency battle dressing stations at strategic points about the hospital. Including main surgery, there were seven emergency dressing casualty stations in readiness for immediate use. At the Pearl Harbor (Navy Yard-Moanaloa) hospital in 1944 there was a ward equipped for handling burn cases and three lockers containing materials for the treatment of burns. A poison antidote locker was maintained in the septic surgery operating room at the Navy Yard hospital.[41]

At the Aiea Heights hospital anesthesia was administered by a specialist who also supervised intravenous and shock therapy in the operating rooms and gas therapy in the wards. Spinal anesthesia was used most frequently at the Pearl Harbor (Navy Yard) hospital in 1943. Occasionally nitrous oxide or cyclopropane were used. Local anesthesia and intravenous sodium pentothal were used successfully in superficial lesions and operations of short duration. At the Pearl Harbor (Navy Yard-Moanaloa) hospital, in 1944, spinal anesthesia, regional blocks, and intravenous anesthesia were the anesthetics of choice.[42]

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40. Annual Sanitary Reports.

41. Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1944.

42. Annual Sanitary Reports from the U. S. Naval Hospital, Pearl Harbor, for 1942, 1943, and 1944.

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The use of sulfonamides played an important part in saving many patients admitted with general peritonitis and other potentially infected operative procedures. A striking record with cases of cerebrospinal fever was achieved through the use of the sulfa drugs at Aiea Heights. Twenty-seven cases were treated, with complete recovery of all cases.[43]

Penicillin was another valuable drug that served to reduce the mortality rate and the period of hospitalization per patient. It was first used in the Pearl Harbor hospitals in 1943. It was used in many compound fractures and in all serious infections. The results in the treatment of head injuries were excellent; many patients with compound skull fractures were treated successfully. Penicillin proved valuable not only for battle casualties but also for patients with syphilis and gonorrhea.[44]

The treatments given to casualties before they arrived at the hospitals undoubtedly contributed to the remarkable record of life-saving surgical operations. The treatment for shock by plasma and whole blood and the early use of the sulfa drugs were a great advantage in preserving life during the period between initial first aid

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43. Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1943 and Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Aiea Heights, for 1944.

44. Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Aiea Heights, 1944.

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and final surgical treatment given by the hospitals. The first-aid practice of leaving wounds open, spraying with sulfanilamide, and splinting for immobilization helped to reduce infection of war wounds.[45]

Each of the hospital at Pearl Harbor had a special department for eye, ear, nose, and throat cases. This department, from the standpoint of the number of patients and staff, was less important than the medical and surgical departments. It may be classed as one of the minor departments of the naval hospitals at Pearl Harbor.

Except for casualties, the largest proportion of the work of the EENT department of the Pearl Harbor (Navy yard-Moanaloa) hospital was surgical in nature. Chronic tonsillitis, deviation of the nasal septum, sinusitis, facial fractures, and lacerations were the most frequent diagnoses. Ocular injuries, foreign bodies in the eyes, iritis, and chorioretinitis were the most frequent eye disorders. A large part of the work of the EENT departments of the Pearl Harbor hospital consisted of consultations, treatments and refractions for men referred from the various units in the Hawaiian area. Among the casualties treated in the EENT department of the Pearl Harbor (Moanaloa) hospital were men with plastic and maxillo-facial surgery and damage to the ear as the result of the blast. Ocular injuries were

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45. Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1944.

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frequent among the casualties received in the EENT department of the hospital in 1944.[46]

In 1944 the total number of admissions to the wards under the EENT department of the Aiea Heights was 2,846, and the average weekly turnover was 55 patients. The number of eye patients was 915; ear, nose, and throat cases numbered 1,931. The greatest number of beds assigned to the EENT department was 301. The total number of operations carried out by the EENT staff at Aiea Heights in 1944 was 1,310. Punctures of the maxillary sinus with irrigation brought the computation to 2,746. General anesthesia was employed in five percent of these cases, while 95 percent of the operations were performed with local anesthetics.[47]

All of the hospitals at Pearl Harbor had separate departments for the laboratories. In addition to rendering services for hospital patients, these laboratories made various tests and examinations for ships of the fleet and local shore establishments. A large part of the work of the Aiea Heights laboratory department was for ships and outlying stations. The work of the laboratories included all the routine procedures, such as hematology, urinalysis, serology, blood chemistry, stool examinations, and microscopic

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46. Annual Sanitary Reports from Naval Hospital, Pearl Harbor, for 1942, 1943, and 1944.

47. Annual Sanitary Report.

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examination of surgical and necropsy specimens. The laboratories at Aiea Heights and the Navy Yard were equipped to carry out some tests and render some services which the mobile and base hospitals and other medical department facilities were not equipped to do. The laboratory at Aiea Heights had a blood and plasma bank, a morgue, a photographic laboratory, and an animal house.[48] Although the primary purpose of the hospital laboratories was to assist in the care of the sick and injured, the laboratories at the Navy Yard and Aiea Heights carried on experimental and research projects. At the Pearl Harbor (Navy Yard) hospital in 1942, the laboratory cooperated with other departments of the hospital in studies of lesions produced by submersion blast. The laboratories also rendered valuable aid to the epidemiological control program. At Aiea Heights in 1943 Epidemiological Unit Number 45 had special facilities in the laboratory department. Among the achievements of this epidemiological unit were (1) epidemiological control of disease at Canton Island, (2) speedy control of the epidemic of food poisoning at the Pearl Harbor submarine base, and the combatting and prevention of disease at Tarawa where thousands of bodies, hosts of flies, and polluted water were potential sources of epidemics.[49]

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48. Annual Sanitary Reports.

49. Annual Sanitary Report from U. S. Naval Hospital, Pearl Harbor, for 1942; Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Aiea Heights, for 1943.

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The floor space, lighting, ventilation, and equipment of the hospital laboratories were generally satisfactory throughout the War. The staffs of medical officers and corpsmen were usually maintained in sufficient strength, although some difficulty was experienced in keeping enough trained and experienced men. The problem of trained personnel was partially solved by courses of instruction conducted at the Pearl Harbor hospitals.[50]

All the Pearl Harbor hospitals had special departments for X-ray. Radiographic and fluoroscopic examinations and therapeutic treatments of superficial pathological conditions constituted the main types of work done by the X-ray departments. Roentgenological studies were made not only for the hospitals but also for ships at Pearl Harbor. Most of the therapy work was superficial in character. The facilities and equipment of the hospital were excellent, and there were few times when the number of trained men was too small for proper service. Instruction in X-ray technique was given at the Aiea Heights hospital.[51]

The physiotherapy departments of the hospitals at Pearl Harbor assumed greater importance as the War progressed and the number of patients requiring rehabilitation increased. Exercise classes for rehabilitation of patients recovering from operations and those

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50. Annual Sanitary Reports.

51. Ibid.

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who needed corrective exercise were conducted by the physiotherapy department. Treatments, given upon written order of ward medical officers, were administered by physiotherapy technicians of the Hospital Corps under the supervision of the head of the department. Through a member of the physiotherapy department who made daily ward rounds in the orthopedic ward with the medical officers, the department kept in close contact with patients and received the orders for treatment directly from the ward medical officers.[52]

To speed the rehabilitation of the wounded, programs of Industrial occupational therapy and physical training were begun at Aiea Heights in 1943. Under the industrial occupational therapy program men were assigned to various training tasks. This industrial occupational therapy proved a very valuable supplement to the manual training and small arts programs already in use. "Through Industrial Occupation Therapy," according to a report for 1943, "many men were returned to duty in a shorter space of time than hitherto possible, and others who might have been badly disabled were enabled to continue either in the naval service on a limited duty status, or were returned to civilian life, physically able to continue as self supporting citizens."[53]

Under the supervision of the welfare and recreation officer,

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52. Annual Sanitary Reports.

53. Historical Data Supplement to Annual Sanitary Report from U. S. Naval Hospital, Aiea Heights, for 1943.

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a program of physical training was offered to men who needed activity other than that provided by the industrial therapy program. The particular kind of activity needed by the individual patient, in both programs, was selected with the advice of the ward medical officer and sometimes after consultation with the orthopedic surgeon. In addition to the usual athletic facilities, this training program utilized bowling alleys, tennis courts, volley ball courts, billiard tables, motion pictures, and a boxing arena.[54]

The Aiea Heights hospital, from its inception, had a separate urological department. At the Pearl Harbor (Navy Yard) hospital on 1 February 1942, the medical officer in command established a department of urology to replace the urological division of the surgical department. The mobile and base hospitals had no separate urological departments.[55]

The urological departments also followed the policy of separating and segregating certain types of patients in certain areas of the wards. At the Pearl Harbor (Navy Yard) hospital in 1943, one ward hospitalized surgical cases of urinary tract calculi; in the other ward were cases of chronic prostatitis, urethritis, stricture of the urethra, and gonococcocus infections. The urological ward at the Aiea Heights hospital in 1943 consisted of two sections,

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54. Ibid.

55. Annual Sanitary Reports.

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one for venereal cases and the other for the medical and surgical cases of a urological nature.[56]

In 1943 the Aiea Heights urological department treated casualties from the combat areas. Gunshot wounds of every organ of the urogenital tract, those of the kidney and bladder predominating, were treated. These patients were rendered fit for duty from a urological standpoint, although it was necessary to evacuate a few because of associated injury to major nerve trunks.[57]

During the last five months of 1943 the use of penicillin in the treatment of urogenital infections was introduced at the Pearl Harbor hospitals. The new drug accomplished remarkable results in curing venereal diseases. At the Aiea Heights Hospital 300 gonococcal infections were treated with this drug and cures were effected in almost 100 percent of the cases. Penicillin therapy resulted in a radical reduction in the average number of hospital days per venereal patient. The period of hospitalization required for the average venereally infected patient was reduced from almost a month to less than a week. At the Pearl Harbor (Navy Yard) hospital in 1943, 160,000 units were given to most patients without any failures; of twelve patients -

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56. Ibid.

57. Annual Sanitary Report.

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who were given only 50,000 units, only one failure was recorded. Urethral discharges usually disappeared within twenty-four hours after the completion of penicillin treatments. A thorough test, which included prostate massages, urethral sounds, posterior instillations, smears, and three negative cultures, was given to each patient to determine whether or not the cure was complete.[58]

Each of the hospitals at Pearl Harbor had dental departments. The dental departments at Aiea Heights was divided into two parts, one for operative surgery and the other for prosthetics. The arrangements for dental surgery at the Aiea Heights hospital were made in preparation for a possible influx of casualties with maxillo-facial injuries. With the exception of emergency cases, all patients were treated upon appointment. The dental departments of the hospitals were exceptionally well equipped and staffed throughout the War.[59]

The medical officer in command of the Aiea Heights hospital had charge of burials of all men who died in the naval hospitals at Pearl Harbor. All bodies were sent to commercial undertakers for embalming, preparation, and encasing before they were delivered to the Aiea Heights hospital. Arrangements for funeral services were made by the Aiea Heights hospital. The remains of men whose resi-

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58. Annual Sanitary Reports from the U. S. Naval Hospital at Pearl Harbor (Navy Yard) and Aiea Heights, for 1943.

59. Annual Sanitary Reports.

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dence was in the Hawaiian Islands were buried in the Navy plots in the Oahu cemetery; all others were buried at the Halawa Cemtery. The district chaplain cooperated with the Aiea Heights hospital in conducting proper religious services for the dead.[60]

Administrative - Clerical Branch

The clinical-professional branch of the Navy hospitals in the Pearl Harbor area was the part of the hospitals most directly and intimately engaged in caring for the sick and injured. This branch of the hospital, however, required the support of the administrative-clerical branch. Such departments as personnel, maintenance, commissary, disbursing, laundry, ship's service, religious services, and educational services were important and indispensable parts of the Pearl Harbor hospital. The assigning of personnel of the staff, provision of necessary supplies and equipment, feeding of thousands of men of the hospital staff and patients, quartering an ever-increasing staff, provision of recreation for both staff and patients, and assiting and counseling men with problems of a private nature were major problems for the naval hospitals at Pearl Harbor throughout the War.[61]

From the standpoint of types of cases and kinds of Navy units served, the hospitals at Pearl Harbor constituted a class

60. Ibid.
61. Ibid.

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intermediate between the base hospitals of the South Pacific and the U. S. naval hospitals of the continental United States. Like base, mobile, and fleet hospitals, many of their patients were battle casualties who had received no previous hospital treatment. Like the continental hospitals, many of their patients were the sick and injured from shore stations and ships in port. Virtually every kind of disease and injury encountered in the Pacific war was treated in the Pearl Harbor hospitals. Each of the principal types of hospital units, i.e., mobile, fleet, base, and U. S. naval hospital, was represented at Pearl Harbor. Virtually every problem of medical and surgical practice and Navy hospital administration was faced by the staffs of the Pearl Harbor hospitals. In brief the group of Navy hospitals at Pearl Harbor may be characterized as a blending of the features of continental and base hospitals. No small group of hospitals, within such a limited area, was more representative of Navy hospitals during the War than those at Pearl Harbor.

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Section 3 Fleet, Mobile, Base, and Special Augmented Hospitals in the Pacific

In the first year of the War, Navy hospitals were established and put into operation in the Hawaiian Islands, American Samoa, New Zealand, New Caledonia, and the New Hebrides.[62] Except in the Hawaiian and New Hebrides Islands, all the hospitals carried the designation "Mobile Hospital." The hospital established at Efate, New Hebrides, was designated Base Hospital Number 2.

Until mid-1944, the two main types of Navy hospitals in the South Pacific Area were the mobile and base hospitals. The differences between these two types of hospitals were not great. The chief differences were usually in size, location, and relationship to the chain of command. The hospitals designated "Mobile" were generally larger than "Base" hospitals, were located in rear areas further removed from the scene of combat operations, and were under the command of a medical officer whose immediate superior was the commander of the fleet to which he was attached. Base hospitals were under the command of a medical officer who was directly under the commanding officer of the naval base upon which the hospital was located. Base hospitals were attached to an officially commissioned naval base. Mobile hospitals were not necessarily attached to a base, could be independent commands,

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62. The account of mobile and base hospitals in the Pacific in 1942 given here is based primarily upon annual sanitary reports. See bibiliography.

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and frequently were not geographically contiguous to a naval base. The medical officer in charge of Base Hospital Number 2, at Efate, New Hebrides, also served as base medical officer, with jurisdiction over all Navy Medical Department activities on the island.

The supplies, equipment, and building materials of the mobile hospitals were procured and assembled by the Medical Supply Depot in Brooklyn. Mobile hospitals were usually commissioned at the Brooklyn Supply Depot. The medical officer in command and his executive officer were appointed before the time of commissioning, and the entire staffs--doctors, dentists, and hospital corpsmen--generally assembled at the place of commissioning.

From the time of commissioning until the materials and equipment of the hospitals were packed for shipping, the staffs of the mobile hospitals underwent a period of training and indoctrination in the administrative, construction, and medical problems associated with Navy mobile and base hospitals. Lectures, special courses in tropical medicine and other medical and sanitation subjects, and instruction for hospital corpsmen in technical specialties were provided. Efforts were made to familiarize all members of the staffs with the equipment of the hospital and with the special markings of identification which were placed on the packages and crates that contained the materiel of the hospital.

The building materials, equipment, and supplies of the

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mobile hospitals were transported from New York by ship. The staffs generally proceeded to the West Coast, where another training period ensued until the personnel were embarked for transportation to the South Pacific.

Upon reaching their destination at one of the island locations in the South Pacific, the staffs of the hospitals immediately set up temporary quarters in tents or buildings already erected. When ships with the materiel of the hospital arrived in the port, hospital corpsmen, under the direction of medical officers and construction battalion officers, began the job of unloading, sorting, and constructing the hospital. During the first year of the War, most of the physical work of construction was actually done by men of the Hospital Corps who had no special training for such work. During the period of construction, only members of the staff and emergency cases were cared for by the hospital.

From the time of commissioning of mobile hospitals until the time they admitted their first patients a period of several months generally elapsed. For Mobile Hospital Number 5, located at Noumea,New Caledonia, almost six months elapsed between the date of commissioning and regular admission of patients; for Mobile Hospital Number 6, located at Wellington, New Zealand, less than two months were required between commissioning and operation.

The buildings of the mobile and base hospitals were predominantly steel, prefabricated structures. The buildings of

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Base Hospital Number 2, at Efate, New Hebrides, were of the Quonset hut type, the Iceland hut type, and sheds of wood and metal. The floor space of the Quonset type hut was 16 by 36 feet; the Iceland hut was 24 by 36 feet, and the sheds were of various sizes. These huts were used as single units or in groups of two or three placed end to end. At Base Hospital Number 2, at the end of 1942, there were 138 huts of the Quonset type, 49 huts of the Iceland type, and 6 sheds. At Mobile Hospital Number 3, American Samoa, the buildings in general were of the Quonset type; storehouses, medical supply storehouses, and recreation buildings were larger. Mobile Hospital Number 4, at Auckland, New Zealand, had a total of 98 buildings on the hospital compound, 44 of which were of prefabricated steel transported from the United States and erected by hospital personnel. The remainder of the buildings at Mobile Number 4 were of frame construction. Mobile Hospital Number 5, Noumea, New Caledonia, had 55 prefabricated steel panel buildings and 3 temporary wooden buildings. Mobile Hospital Number 6, near Wellington, New Zealand, did not use the metal, prefabricated buildings originally assigned to it. All buildings at Mobile Number 6, except three prefabricated steel buildings, were constructed of local timber with asbestos roofing.

Base Hospital Number 2, at Efate, New Hebrides, experienced difficulties in obtaining and maintaining sufficient medical supplies.

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Shortages of quinine and atabrine, critically needed for both chemoprophylaxis and therapy, "presented insuperable difficulties."[63] Some 4,800 five-grain tablets of quinine dihydrochloride were purchased from a local insurance company and an additional supply of 96,000 five-grain tablets arrived a month later by air from a nearby base. The estimated need per month for the hospital unit along was 36,000 tablets for chemoprophylaxis and 20,000 for therapy.

There was apparently some confusion as to the correct procedures for requisitioning and accounting for supplies at Base Hospital Number 2. According to the annual sanitary report for 1942, the allotment status of the hospital was unknown; instructions in regard to accounting procedures had not been received; the hospital was without information as to how to obtain items not listed in the Supply Catalogue, and there was uncertainty about what course to follow when certain items requisitioned were omitted from shipments because they were not available at the depot or storehouse.

Other hospitals reported fewer supply difficulties. Mobile Hospital Number 5, at Noumea, New Caledonia, reported that supplies had been "ample, of excellent quality, and in good condition on arrival."[64] Mobile Hospital Number 3, American Samoa, reported that supplies "on the whole have been found to be adequate

63. Annual sanitary report from Base Hospital Number 2 for 1942.

64. Annual sanitary report from Mobile Hospital Number 5 for 1942.

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in quantity and excellent in quality."[65]

The amount of furniture, linens, blankets, litters, wheel stretchers, and similar equipment in the commissioning outfit generally proved sufficient for the standard bed capacity of the hospitals. However, when the actual census exceeded the bed capacity, as frequently occurred at Base Hospital Number 2, additional items had to be obtained from local sources. Some deterioration of metal furniture as a result of climatic conditions was reported by Mobile Hospital Number 3, American Samoa. This hospital also reported that kerosene refrigerators were more suitable than electric ones in the area of its location.

The composition and size of the hospital staffs at the mobile and base hospitals varied. The number of medical officers ranged between approximately 40 and 54, the number of hospital corpsmen between 235 and 500, the number of dentists from 1 to 4, and the number of Hospital Corps officers from 1 to 5. There were, also usually about 80 enlisted men with non-medical ratings. There were no civilian employees for these hospitals, and until the very close of the year, none of the hospitals had Navy nurses.

The authorized complements of the mobile and base hospitals were generally considered sufficient for the authorized

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65. Annual Sanitary report from Mobile Hospital Number 3 for 1942.

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bed capacity, and, in general, the authorized complements were filled successfully. Mobile Hospital Number 5, however, which supplied medical officer replacements to the fleet and shore stations of the South Pacific area, at times had insufficient medical officers available.

Base Hospital Number 2, Efate, New Hebrides, the first Navy Medical Department hospital established in the Southwest Pacific, treated a total of 3,020 patients between 20 September and 31 December 1942. Mobile Hospital Number 3, in American Samoa, treated 1,385 patients in 1942; Mobile Hospital Number 5, at Noumea, New Caledonia, treated 1,138 patients in 1942.

Mobile Hospital Number 3 was the only one of the group established in the Pacific in 1942 which did not receive a large number of battle casualties. This hospital was primarily engaged in caring for Navy and Marine Corps personnel stationed in American Samoa as well as caring for the island natives.

Base Hospital Number 2, at Efate, New Hebrides, received battle casualties by airplanes from the combat area throughout the Guadalcanal campaign. Mobile Hospital Number 6 (Wellington, N.Z.) received 159 casualties from the Solomons on 8 September. Mobile Hospital Number 5 (Noumea, New Caledonia) received its first draft of battle casualties from Guadalcanal on 19 November 1942.

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Casualties from the fighting front at Guadalcanal were received at Base Hospital Number 2 after an average elapsed time of about 36 hours. A small number of patients received at Base Hospital Number 2 were transported by ships from the field hospital at Base "Cactus" to Vila, New Hebrides. Most of the patients, however, were brought by air to an airfield six miles from the hospital. A Quonset hut for the reception of patients was placed near the landing strip of the airfield. A medical officer and hospital corpsman supervised the transfer of the patients from the airplanes to ambulances for further transportation to Base Hospital Number 2. All casualties were divided into four classes:

Class A--convalescent expectancy of less than 90 days.

Class B--psychoneuroses, war neuroses, and situational neuroses.

Class C--convalescent expectancy of over 90 days.

Class D--permanently disabled for further duty in the South Pacific Area.

Patients classified A were permitted to return to duty upon recovery. Patients classified B, C, or D were transferred to the hospital ship USS SOLACE or the hospital transport USS TRYON for disposition. Class D patients were evacuated to the United States by means of hospital ships, hospital transports, and certain other specified transports.

Mobile Hospital Number 6, near Wellington, New Zealand, received battle casualties who had been transported by ship. Many

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patients were brought to New Zealand by the hospital ship SOLACE. All patients transferred from the SOLACE to Mobile Hospital Number 6 were classified and tagged by the doctors aboard the ship. Before the patients left the ship, officers from the mobile hospital assigned them to their wards. Patients were transported from Wellington by means of specially built hospital trains. After arrival at the hospital, they were unloaded at the hospital siding and moved in ambulances to the various wards. Small groups and individual patients were transported from ships in the Wellington harbor by ambulances provided by the hospital. Patients brought to the hospital from Marine Corps camps in the Wellington area came by trucks or other vehicles provided by the camps.

Sick and injured were transported to Mobile Hospital Number 3 (American Samoa) by plane, ship, and automobile. Transportation of patients from Mobile Hospital Number 3 was by hospital ambulances. All trips made by the ambulances out of the hospital area were logged with the name of the driver, number of the ambulance, time of departure, destination, and time of return. Upon departure, the driver received a numbered pass which he turned into the office of the medical officer of the day when he returned.

Three or four field type ambulances were included in the original commissioning outfit. The ambulances provided were rough riding and some complaints were voiced against their use in the

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transportation of seriously ill patients. Base Hospital Number 2 exchanged three of its ambulances for three of another make with the local Army medical organization. The four ambulances were not enough when patients in large numbers had to be transported, and additional ambulances located on the island had to be utilized.

The internal organization of the mobile and base hospitals established in the South Pacific in 1942 was similar to that of the continental hospitals. The two principal subdivisions under the medical officer in command and the executive officer were the professional and administrative branches. Under the professional branch the two chief divisions were the medical department and the surgical department. In addition to these basic departments there were several special departments. The laboratory, eye-ear-nose-and-throat service, neuropsychiatric service, and dental service were special departments at Base Hospital Number 2. Mobile Hospital Number 3 at American Samoa had special departments for laboratory, eye-ear-nose-and-throat cases, dental cases, out-patients, post office, and ship's service. The special departments at Mobile Hospital Number 5 were eye-ear-nose-and-throat, X-ray, dental, anesthesia, and urology.

The medical departments were generally only slightly smaller than the surgical departments. The total bed capacity of the medical department of Mobile Hospital Number 2 was 187 beds, while the total bed capacity of the surgical department was 219. At Base

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Hospital Number 2, the percentage of admissions assigned to the medical department fluctuated between 40 and 50. These percentages were influenced at any particular time largely by the varying influx of patients with malaria or wounds acquired in combat. For example, during December 1942, of the 717 admissions for all causes, 211, or 29.8 percent were admitted for malaria.

In 1943 Navy hospital facilities in the South Pacific multiplied at a rapid rate.[66] Nine Navy hospitals in all were put into operation in the South Pacific area. Four of the nine were of the mobile class; the remainder were base hospitals. These additional hospitals were located in the New Hebrides, New Caledonia, New Zealand, Australia, the Solomon Islands, and New Guinea. The two new hospitals added in New Caledonia were base hospitals and were located at Espiritu Santo. The additional hospital established in New Caledonia was of the mobile type and was, like Mobile Hospital Number 5, set up at Noumea. In New Zealand, a second Mobile Hospital--Number 6--was located at Auckland. In Australia, Mobile Hospital Number 9 was established at Brisbane and Base Hospital Number 10 at Sydney. In the Solomons, Mobile Hospital Number 8 was established at Guadalcanal, and Base Hospital Number 7 at Tulagi. In New Guinea, Base Hospital Number 13 was put into operation at Milne Bay. Most of these hospitals began operating in the last half of the year. Only

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66. The account of mobile and base hospitals in the Pacific in 1943 given here is based primarily upon annual sanitary reports and historical data supplements to the annual sanitary reports. See bibliography.

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two of the hospitals--Mobile Hospital Number 7 at Noumea, New Caledonia, and Base Hospital Number 6 at Espiritu Santo--began operations in the first half of the year. In August, Base Hospital Number 7, Tulagi, Mobile Hospital Number 8 at Guadalcanal, and Base Hospital Number 3 at Espiritu Santo were established; in October, Mobile Hospital Number 9 at Brisbane and Mobile Hospital Number 6 at Auckland were established; in November, Base Hospital Number 10 was commissioned; and in December, Base Hospital Number 13 was established at Milne Bay, New Guinea.

Throughout 1943 the character of the work done by the Navy hospitals in the South Pacific did not change, although the total load increased tremendously. Men with tropical diseases, especially malaria, and wounded men from the Solomons campaign constituted a large part of the patients admitted to the hospitals. The hospitals continued to serve to a great extent as evacuation centers; this was especially true of base hospitals in the more advanced areas which evacuated patients to rear area hospitals. Men from all the American and allied services were received for treatment.

The staffs of the five Navy hospitals which had been put into operation in the South Pacific in 1942 were expanded to take care of the greatly increased number of patients that streamed in from the Navy and Marine Corps battles and campaigns in 1943. Base Hospital Number 2, at Efate, New Hebrides, first of the base hospitals established

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and operated for the reception and care of casualties in the Southern Pacific, increased its staff from 420 on 1 January 1943, to 537 on 1 January 1944. Mobile Hospital Number 3, in American Samoa, which had had an average strength of 23 officers and 255 enlisted men in 1942, had in 1943 an average of 34 officers and 301 enlisted men. Mobile Hospital Number 5, at Noumea, New Caledonia, increased its staff from an average strength of 33 officers and 235 enlisted men in 1942 to 45 officers, 465 enlisted men, and 28 nurses in 1943.

The new Navy hospitals established in the South Pacific in 1943 generally had from 40 to 50 officers, 400 to 500 enlisted men, and 0 to 40 nurses. Base Hospital Number 10 established at Sydney in November, however, had an average strength of 20 officers, 192 enlisted men, and 19 nurses.

Most of the hospitals which had been erected in 1942 treated between 10,000 and 15,000 patients in 1943. Mobile Hospital Number 3, in American Samoa, however, treated 6,979 patients. The various hospitals that began in 1943 varied a great deal in the total number of patients treated, according to size and time of inception. For example, Mobile Hospital Number 7 (a hospital of about 2,000-bed capacity by the close of the year), which received its first patients on 22 April treated 8,091 patients, while Base Hospital Number 10, which was commissioned 24 December treated a

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total of 536. Nevertheless, some of the hospitals established as late as August treated large numbers of patients. Mobile Hospital Number 8, at Guadalcanal and Base Hospital Number 3, at Espiritu Santo, both of which received their first patients in August, treated a total of 11,105 and 10,609 patients respectively.

For most of the hospitals, the rate of admissions was highest during the period January-September, while the campaign in the Solomons was still in progress. After September, casualties from the forward area by-passed Base Hospital Number 2 at Efate, New Hebrides, for other hospitals farther south. Mobile Hospital Number 6, at Wellington, after the cessation of the Solomon Islands campaign, provided medical care for the First and Second Divisions while they were still stationed in the Wellington area and served as the major medical department hospital unit for the southern part of the North Island of New Zealand.

Malaria continued in 1943 to be a paramount medical problem for the Navy hospitals of the South Pacific. Base Hospital Number 2, at Efate, New Hebrides, during 1943, admitted a total of 3,050 cases of malaria, of which 2,119 originated on naval bases other than the one upon which it was located. By March 1943, malaria was the "primary problem" for Mobile Hospital Number 6 at Wellington; on 6 March, 870 patients, or 76 percent of the total, had malaria. For the successor to Mobile Hospital Number 6 near Wellington--Base Hospital Number 4 -- malaria continued to be the most pressing medical problem. Accounting

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for about 12 percent of all admissions to Mobile Hospital Number 8 at Guadalcanal, malaria was one of the most common diseases treated.

A second class of non-surgical cases that became a problem of increasing importance in 1943 were the psychoneuroses and nervous conditions precipitated by monotony, fatigue, and combat experiences. At Mobile Hospital Number 8 (Guadalcanal), 2,208 patients, or almost 22 percent of the total admissions, were admitted to the neuropsychiatric service. Base Hospital Number 3 (Espiritu Santo, New Hebrides) admitted over 700 neuropsychiatric casualties and from 20 to 40 percent of the patients had neuropsychiatric or related diagnoses; only about 6 percent of the neuropsychiatric patients at Base Hospital Number 3 were psychotic (mentally deranged). Mobile Hospital Number 3 (American Samoa) had a steadily rising number of neuropsychiatric cases during the year; most of these cases were from organizations which had not seen active combat but had been subjected to long and monotonous training duty in a tropical climate.

Filariasis continued as a major problem for Mobile Hospital Number 3 in American Samoa. Up to 1 January 1944, this hospital evacuated to the United States a total of 2,904 cases with filarial involvement. Other mobile and base hospitals in the South Pacific also reported an increasing incidence of filariasis among both combatant and noncombatant units. Several annual sanitary reports noted that units from which large number of filarial cases originated

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had been previously stationed in Samoa.

In 1944 ten new Navy hospitals of the base and mobile type were put in operation in the Pacific.[67] Hospitals were established in the Solomons, New Guinea, Marianas, Admiralty Islands, Schouten Islands, Caroline Islands, and at San Francisco. Most of these hospitals were of the base type and were commissioned at locations which had only recently been liberated from enemy territory. The base hospitals generally originated from G-2 components and developed into base hospitals after several months service as dispensaries.

In mid-1944 the type of hospitals known from the beginning of the War as "Mobile Hospitals" were redesignated "Fleet Hospitals", and the newly commissioned hospitals other than the base hospitals were also designated "Fleet Hospitals."

In 1943 and 1944 there were no radical changes in the administrative organization, the building construction, the hospital equipment, or clinical practice of the Navy hospitals in the

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67. The account of mobile and base hospitals in the Pacific in 1944 given here is based primarily upon annual sanitary reports for 1944, historical data supplements to annual sanitary reports for 1944, cumulative history reports, correspondence and reports in the personal files of the Surgeon General and the Bureau of Medicine and Surgery. See bibliography.

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Pacific. There were, however, numerous changes relating to developments and improvements along lines fairly well established as early as the first quarter of 1943. Equipment for specialization of medical and surgical practice were added to most of the hospitals. The instructional programs for hospitals staffs became more systematic. In time, too, there were many additions to the recreational facilities, the absence of which were felt rather keenly by both patients and staff during the first year of the War by those hospitals not located near the New Zealand and Australian cities.

The commencement of penicillin treatment in the latter part of 1943 was perhaps the most significant therapeutic development in the hospitals. The character of diseases and injuries in 1944 was marked by a decline in the number of patients with malaria and filariasis. Like the Hawaiian and Continental hospitals, the mobile-fleet and base hospitals of the South Pacific placed increased emphasis on physical therapy and other programs that could serve to rehabilitate convalescent patients.

Certain hospitals were designated to received particular kinds of cases. In November 1943, Mobile Hospital Number 6, Auckland, New Zealand, was designated as a special center for the treatment of patients suffering from combat fatigue, war neuroses, and mild mental disorders. When Mobile Number 6 was closed, Base Hospital Number 6 at Espiritu Santo was designated by Commander

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South Pacific as the special center for such neuropsychiatric cases. In November 1943, an ophthalmic center for major ophthalmic surgery was established at Mobile Hospital Number 7, Noumea, New Caledonia.

In 1942 and 1943 it was possible to transfer patients to the United States only from base and mobile hospitals in the rear areas. Such an arrangement was not the best for the economical use of hospitals beds and transportation; and a directive from the headquarters of the South Pacific Force, dated 24 January 1944, made it possible for any base or mobile hospital in the forward area to evacuate directly to the United States those patients who were permanently disabled or who would require more than 120 days' treatment. The purpose of the directive was to prevent patients of these two categories from passing through four or five hospitals before they were eventually transferred to the United States. Such a policy made more beds available in the forward area, and patients could be evacuated sooner because transportation was more abundant in the forward than in the rear areas. The directive of 24 January 1944 also forbade the evacuation to New Zealand of patients destined for the United States, because of the great difficulty of obtaining shipping from that island.

From an administrative standpoint, one of the important events of 1944 was the appointment by the Commander South Pacific Area and South Pacific Force of a special board to formulate plans

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for the standardization of mobile hospital construction. This board submitted a comprehensive report on all aspects of these hospitals. Although most of the report was devoted to the standardization of specifications of buildings and equipment, the board did not fail to comment on other features of the hospitals and to make recommendations accordingly. The seventeen-page report of this board is probably the best single source of information on the material and construction problem of the mobile fleet hospitals.[68]

Some of the hospitals which had been established in the first year of the War and which were becoming more removed from the advancing areas of combat showed a declining proportion of battle casualties in 1944. As early as May of that year tentative plans were being made to reduce the number of hospital beds in the South Pacific Area from about 12,000 to 4,000 beds by the first of January 1945. It was felt than that most of the hospitals in the South Pacific would probably be needed in some other area and that it was advisable to begin knocking them down and making them ready for shipment when the need for them developed. A revised plan in June called for a reduction from the peak of over 15,000 beds reached in March to around 9,000 by the close of the year.

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68. A copy of this report is attached to the annual sanitary report for 1943 from Mobile Hospital No. 5.

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Some of the hospitals which had been set up in 1942 and 1943 were dismantled in 1944 and packed for shipping to other locations in the Central and Western Pacific. Mobile Hospital Number 3 in American Samoa, in accordance with an order of the Commander South Pacific Force, ceased to function as a hospital on 1 April 1944; packing of supplies and equipment and dismantling and crating of buildings was completed on 29 April, on which date the largest part of the material had already been transferred to the Naval Station for storage while awaiting shipment. Base Hospital Number 4, Wellington, New Zealand, by order of the Commander South Pacific, ceased to function as a hospital on 1 April 1944, and the work of dismantling, packing, and crating was carried out in accordance with an approved movement plan. Mobile Hospital Number 4, at Auckland, New Zealand, ceased to function on 1 July 1944; patients who were not ready for duty were transferred to other hospitals in the South Pacific area and the dismantling, packing, and crating was begun. Mobile Hospital Number 6 (Fleet Hospital 106), also at Auckland, New Zealand, began preparations for dismantling on 10 May 1944, when the hospital was placed in ordinary commision and ceased to function as a hospital. Base Hospital Number 2, at Efate, New Hebrides, which ceased to function on 1 August 1944, was shipped on 1 November to Noumea, New Caledonia, for staging. Base Hospital Number 11, at Munda, New Georgia, decommissioned 15 December 1944, was dismantled

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and forwarded in order to enlarge Base Hospital Number 17 at Hollandia, New Guinea.

By the middle of October 1944, Fleet Hospitals 104 and 106 had been moved to Noumea for rehabilitation and staging. Fleet Hospital 112, which had not yet been put into service in the Pacific and which had left the United States in May 1944, was staging in the Russells. Base Hospital Number 2 had been dismantled and was scheduled to be brought from Efate to Noumea for staging as soon as shipping was available. Base Hospital Number 4 was being reconstituted at Espiritu Santo. Of the remaining hospitals functioning in the South Pacific, it was thought that at least four would be rolled up in early 1945.

By January 1945, Navy hospitals in the South Pacific Area had already been sharply curtailed. Several mobile and base hospitals had been packed and shipped to centers where they awaited further disposition. At Noumea were concentrated Base Hospital Number 2 (formerly at Efate, New Hebrides), Fleet Hospital 104 (formerly at Auckland, New Zealand), and Fleet Hospital 106 (formerly at Auckland, New Zealand). Base Hospital Number 4 (formerly at Wellington, New Zealand, was at Espritu Santo, New Hebrides. The convalescent section of Fleet Hospital 107 at Noumea and Base Hospital Number 7 at Tulagi, Solomon Islands, were in the process of folding up and being packed for forward movement. Fleet Hospital 112, which had never been set up, was in the Russell Islands.

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The commanding officers of the inactive hospitals at Noumea were in frequent conference with a captain of the Medical Corps in planning for the shipment and installation of these hospitals in forward areas.

In mid-April Fleet Hospitals 105 (Noumea), 108 (Guadalcanal), 110 (the Russell Islands) and Base Hospital Number 3 (Espiritu Santo) were still in operation. Most of the hospitals were averaging about 300 patients, with the exception of Fleet Hospital 108, which had about 500, 200 of which were to be transferred to the United States. Closed and packed were Fleet Hospital 107 (Noumea) and Base Hospital Number 6 at Espiritu Santo. Base Hospital Number 7 at Tulagi, Solomon Islands, was ordered decommissioned as of 15 April and was not to be reconstituted. On 23 April, Base Hospital Number 13 at Milne Bay, New Guinea, and Base Hospital Number 14 at Finshhafen, New Guinea, were rolled up and plans were being made to combine them for eventual service in the Philippines. The plans at this time called for cutting the remaining hospitals to 300-bed capacity and eventually replacing them with dispensaries. On 26 May the list of hospitals earmarked for forward movement included Fleet Hospitals 105, 106, 110, 107, and 104, and Base Hospitals Numbers 3 and 6.

Only a small proportion of the Navy hospitals in the South Pacific were relocated in the more western and central parts

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of the Pacific before the War ended. On Guam, Fleet Hospital 103 (formerly at American Samoa), was set up and received its first patients, from Okinawa, on 1 April 1945. In the Philippines, in the Samar area, Fleet Hospital 109(decommissioned at Brisbane, Australia, 6 January 1945) was combined with Fleet Hospital 114, which had as yet seen no service in the Pacific; this amalgamated hospital, under the designation of Fleet Hospital 114, received its first patients on 4 July 1945. Base Hospital Number 2 (formerly at Efate) was moved to Subic, P. I., but was not in operation when the War came to an end. Base Hospital Number 14 (formerly at Finschhafen, New Guinea) was moved to Cavite, P. I. Fleet Hospitals 104 and 112 did not reach Okinawa until after the Japanese surrender. Base Hospital Number 4 (which had ceased to operate at Wellington, New Zealand on 1 April, 1944 and which had been reactivated on 22 February, 1945) and Base Hospital Number 6 (which had been at Espiritu Santo from mid-1943 until February 1945) arrived and were amalgamated but admitted no patients before the surrender. The staffs of Fleet Hospitals 104, 106, and 107 were in Okinawa when the War ended. Fleet Hospital 106 (which had operated at Auckland, New Zealand from October 1943 until the summer of 1944) arrived at Okinawa but was not built because of the cessation of the War. Fleet Hospital 108 (at Guadalcanal) was staging at the time of the Japanese surrender.

Only a few hospitals were put into operation for the

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first time in 1945. Fleet Hospitals 111 and 115 were established in Guam, and Fleet Hospital 114 was erected in the Philippines. Fleet Hospital 116, commissioned at Lido Beach, N. Y., 2 June 1945, was in Okinawa when the War ended but had cared for no patients.

The fleet (mobile) and base hospital successfully hospitalized thousands of patients during the Pacific war. From the standpoint of providing temporary hospitals in the forward and rear areas, their great worth was disputed in none of the annual sanitary reports, historical data reports, inspection reports, or in personal correspondence of the Surgeon General. However, these Navy hospitals never attained the degree of mobility desired for combat areas or areas proximate to combat areas. The deficiencies of the fleet and base hospitals for advanced and combat areas was concisely stated by the author of the annual sanitary report fro the Seventh Fleet for the year 1944; this report, dated 1 April 1945, stated:

> Although Fleet and Base Hospitals as presently planned are excellent as to comfort for patients and working conditions for Medical Department personnel, they do possess the distinct disadvantage that they are bulky and require considerable shipping space to transport, and time and effort to establish; even more is necessary to dismantle, refit, and move forward. In a fast-moving type of warfare over vast distances as has typified operations in the Southwest Pacific, Naval Hospitals have not been capable of receiving casualties until the assault beaches have moved far ahead, often over 1000 miles. With the consistent shortage of AH'S, APH's and APA's in the Seventh Fleet, it has been necessary to resort to hospitalizing Naval patients in Army hospitals in many areas. The latter are easily transported and quickly erected, and while they do not afford many of the refinements of the less

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requirements of the less mobile Naval Hospitals, are able to offer excellent early care to casualties at a time when the need is urgent. Canvas-housed, truly mobile hospitals are a paramount need in Amphibious warfare, both for Army and Navy support.

In 1945, in the closing months of the War, at Okinawa, a new type of hospital was used for the first time.[69] This was a type designated "Special Augmented Hospital." In its composition and function it was intermediate between the field hospital of the Marine Corps and the fleet and base hospitals which had been used throughout the war in the Pacific. These special augmented hospitals were designed to bring hospital services such as X-ray, surgery, dentistry, laboratory, and neuropsychiatry to the immediate vicinity of the combat area.

Plans were made by the Bureau of Medicine and Surgery and the Navy Department for eight of these new hospitals. Four were to have a bed capacity of 200 each and four to have a bed capacity of 400 each. Of the number planned, five left the United States and went to Okinawa.

Personnel for the special augmented hospitals began to assemble at San Bruno, California, in the late summer of 1944. In September, personnel assigned to these hospitals were transferred to Shoemaker, California, for a comprehensive program of physical

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69. This account of the special augmented hospitals is based upon the cumulative history reports from units listed in the bibliography.

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conditioning and professional training. Training which included hiking and camping expeditions under conditions that approximated those met with in the field of combat was conducted at the California base. The men lived in tents, ate out of mess kits, practiced field sanitation, and were instructed in infiltration tactics, use of the rifle, tent construction and maintenance, and chemical warfare. Special groups received instruction in tropical and Oriental disease at the Navy's special school for tropical diseases located at Treasure Island, California. General duty corpsmen were given refresher courses in the regular Hospital Corps subjects, and some men were detailed to neighboring Navy hospitals for training in specialities such as laboratory and X-ray.

Special Augmented Hospital Number 6 was commissioned on 7 March 1945, and three days later Special Augmented Hospitals Numbers 3, 4, 8, and 7 were commissioned. Special Augmented Hospital Number 6, the first to sail, arrived at Okinawa on 4 May 1945, and received its first patients on 17 June 1945. This was the only special augmented hospital that actually received patients before the island was declared secure on 30 June 1945. The other hospitals, however, arrived at a time when there was still a necessity to maintain armed sentries to guard against snipers. Special Augmented Hospital Number 6 debarked at Okinawa on 4 May, and Special Augmented Hospitals Numbers 4, 8, and 7 on 14 July 1945. Of the five special augmented hospitals to arrive in Okinawa, only 3 and 6 actually received patients before the surrender of Japan. The others received their first patients in September, and continued to care for patients for several months.

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Special augmented hospitals were organized to function as individual hospitals under separate commands, although the probability of combination was foreseen. Special Augmented Hospitals Numbers 6, 3, 7, 8, and 4 were under the command of and directly responsible to the U. S. Naval Operating Base on Okinawa.

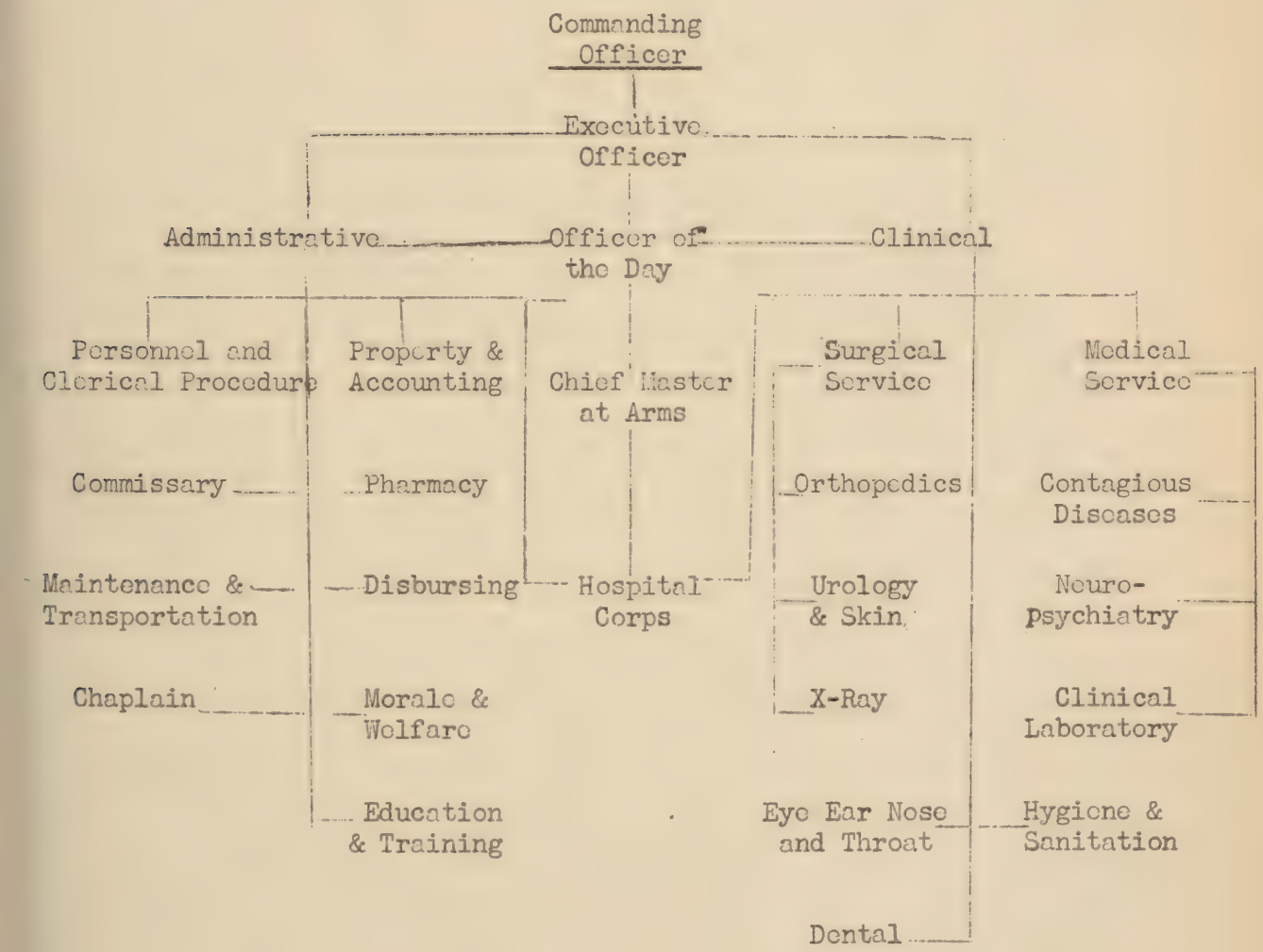
The internal organization of the special augmented hospitals was subdivided according to the plan generally followed in Navy hospitals. At the top of the administrative hierarchy were the commanding officer, the executive officer, and the officer of the day. The two principal branches under the executive officer were the administrative and clinical. Under the administrative branch were sections, offices, and shops which included activities and services such as personnel and clerical procedure, property and accounting, commissary, pharmacy, maintenance and transportation, disbursing, chaplain, morale and welfare, education and training. The clinical branch was divided into the medical and surgical services. The surgical service comprised orthopedics, urology and dermatology, X-ray, eye-ear-nose-and-throat, and dentistry; while the medical included contagious diseases, neuropsychiatry, clinical laboratory, and hygiene and sanitation. The chiefs of each service were the senior medical officer assigned to the services. All medical officers in charge of wards and special departments were under the supervision of the chiefs of the services.

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U. S. NAVAL
SPECIAL AUGMENTED HOSPITAL NUMBER SIX COMBINED

-600 Bed Capacity-

Administrative and Clinical Organization



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The hospital wards, living quarters for staffs, offices, storerooms, and most of the special departments were housed in tents. Operating rooms and X-ray were housed in Quonset huts. The ward tents usually contained about 14 standard cots without mattresses. Lighting in the wards was provided by overhead electric lights and floor outlets. Construction of the special augmented hospitals in Okinawa was by construction battalions assisted by the hospital staffs.

The patients cared for by the special augmented hospitals included the sick and injured from shore-based facilities in Okinawa, and casualties from ships at sea, from bombers, from sniper fire, and from accidents. At the height of their activity, these hospitals were caring for between 200 and 300 patients daily. The peak load for Special Augmented Hospital Number 3 was reached on 20 September, when the census stood at 462. The total number of Navy patients admitted to Special Augmented Hospital Number 8 between 8 September 1945 and 5 January 1946 was 1,611. During the period 1 July-15 December, 2,369 patients were admitted to Special Augmented Hospital Number 6.

Many of the patients from the special augmented hospitals were returned to duty. Of 2,369 patients admitted to Special Augmented Hospital Number 6, only about 700 were evacuated. Those who required prolonged or specialized treatment or lengthy convalescence were evacuated to fleet or base hospitals. Guam was the destination for a large proportion of the patients evacuated by the special augmented hospitals on Okinawa. Evacuees were transported by both airplanes and

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ships. Special Augmented Hospital Number 8 evacuated 240 by air and 483 by ship; the maximum weekly evacuation from this hospital was 95 and the minimum 7, with an average weekly evacuation by air of 37.

Rapid evacuations from the special augmented hospitals brought about a rather sharp reduction in the total number of patients enrolled in the hospitals and by the close of October the patient load had declined appreciably. On 25 October, Special Augmented Hospitals Numbers 3 and 6 were combined; on 9 December, admissions to this combined hospital were discontinued and the remaining patients transferred to Fleet Hospital 106 and Special Augmented Hospital Number 8. On 25 October, Special Augmented Hospital Number 8 absorbed the personnel and material of Special Augmented Hospital Number 7 which was decommissioned on the same day. On 30 November, Special Augment Hospital Number 4 was disestablished and all facilities, material, and remaining personnel, including patients, were transferred to Fleet Hospital 116. On 25 January, Special Augmented Hospital Number 8 was decommissioned.

Because of the termination of the War, the special augmented hospitals were not able to fulfill the mission for which they were primarily intended. Planned to provide hospital facilities in proximity to combat areas, most of their patients were actually received during the period immediately after the Japanese surrender. In general, the reports submitted by these hospitals were quite favorable as to their performance and utility.

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Of the conclusions expressed in the cumulative history reports from these units, that from Special Augmented Hospital Number 8 was most critical:

> Although the exact place of this hospital in the medical facilities picture as a whole was never made clear, nevertheless, certain comments can be made. If it was intended that this hospital should be in operation to function during the active campaign for the island, then its equipment and construction contained too much of a semi-permanent or permanent character so that it could not be erected quickly. On the other hand, if it was intended that this hospital should come into operation after the termination of hostilities, as was the case, then its construction was of too temporary a character to afford desired comfort and efficiency.
>
> Not knowing what the planned expectations for such a hospital were, it is difficult to judge its effectiveness. Probably the most effective function of the hospital was the ability to keep beds available for the demand for admissions which was placed upon it; however, because evacuations had to be made so frequently, prolonged treatment, elective surgery and complete diagnostic procedures had to be curtailed.

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Section 4 Naval Dispensaries in the Pacific During World War II

Throughout the war in the Pacific, naval dispensaries served as integral components of medical planning. Varying from place to place in size, services and function, they provided a network of primary medical care.[70] As the scope of the American offensive was widened and new island bases came under naval authority, the need for increased dispensary facilities became apparent. The story of naval dispensaries in the Pacific Ocean during the war years has been one of considerable expansion. New types of dispensaries were established and sent out to Pacific bases, following shortly on the advances of combat troops. Rear area facilities were enlarged, and new dispensaries mushroomed with every new naval or Marine Corps unit that set up facilities on captured Pacific islands.

From an administrative standpoint, Pacific dispensaries operated under four great echelons of command in the Pacific: (1) dispensaries attached to naval facilities at the Hawaiian Islands were under the authority of the Fourteenth Naval District;[71] (2) the majority

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70. The term dispensary, in the Navy Medical Department, has been a rather amorphous one, used as a result of custom rather than with any legal basis. As cited in Chapter XI, however, dispensaries were given a definition by Rear Admiral Agnew, (MC), USN, as medical facilities (other than naval hospitals) at all shore establishments which "provided for the immediate temporary care of the sick and injured," and which "are usually located in separate buildings or in suitable places in buildings."

71. Dispensaries at Alaska and in the Aleutians were under the command of the Seventeenth Naval District after its establishment in 1944.

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of the other Pacific island dispensaries were under the Commander Service Forces, in the Pacific Fleet organization; (3) dispensaries attached to naval air units in the Pacific, outside of the Fourteenth Naval District, operated under the Commander Naval Air Forces, Pacific Fleet; (4) a small number of dispensaries, attached to Fleet Marine Force shore facilities, were under the authority of the Commander Amphibious Forces, Pacific.

Within these four over-all commands, dispensaries may perhaps most effectively be considered in relation to the activities they served. Dispensaries attached to various units at permanent naval establishments, as at Hawaii, had essentially similar structures. Advanced base dispensaries, following rapidly in the wake of the combat forces, were more mobile in nature. Naval and Marine aircraft activities maintained dispensaries which were primarily concerned with health problems of aviation personnel. Amphibious force dispensaries, on the other hand, were primarily interested in maintaining the health of land combat troops at amphibious transient, training and service centers.

A distinction must be made at the outset between the over-all medical services rendered by Pacific dispensaries and medical service provided by combat medical battalions and medical companies during Pacific campaigns. With the exception of some advanced base air facilities and amphibious force dispensaries, the majority of the dispensaries in the Pacific rendered medical aid to naval units not in immediate combat. Even amphibious force dispensaries functioned largely behind the area

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of combat. Medical battalion and company aid stations went into combat with naval and Marine forces and provided a much more varied type of service than did dispensaries attached to Pacific commands.

Size differed greatly in Pacific dispensaries. Some of the large advanced base units contained up to 600 beds, while other dispensaries contained fewer than 10. The functions of Pacific dispensaries also varied. Essentially, the basic purpose of all Pacific dispensaries was to provide medical care for all naval or Marine Corps personnel within the immediate command to which the dispensaries were attached. The dispensaries differed markedly in this from the naval hospitals - which extended their facilities to naval and Marine Corps personnel wherever they were attached. In practice, however, the extent of the services rendered by Pacific dispensaries depended upon their physical proximity to a naval hospital. Where hospital facilities were close at hand, dispensary functions might be limited to out-patient treatment, diagnosis, emergency treatment or occasional hospitalization for short periods for minor ailments. In island areas where hospitals were at a distance, dispensary functions were extended to include many of the services customarily provided by naval hospitals.

Fourteenth Naval District Dispensaries

Many of the dispensaries under the administration of the Fourteenth Naval District can be more easily considered if treated in a separate section from other Pacific dispensaries. The Hawaiian

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area dispensary facilities were more closely related to stateside dispensaries than to naval dispensaries set up on the islands along the route to the Japanese mainland. In large part, on the outbreak of War, the pattern of dispensaries in Hawaii had already been established, and their problems were those of expanding and adapting already set up facilities, rather than establishing an entirely new program of medical care and dispensary installation. Further, the problem of care of naval and Marine Corps dependents did not exist west of Hawaii, but it was an actual part of dispensary care in Hawaii, as in the United States proper.

A great variety of dispensaries, however, existed under Fourteenth Naval District command during the War.[72] Typing them

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72. As of May 1944 the following were in operation:

Pearl Harbor Area - OAHU	Number of Beds
Dispensary Receiving Station	14
Dispensary Receiving Station, Aiea Heights	41
Dispensary Marine Barracks (casualty station available but not in use)	30
Dispensary Marine Garrison Forces, 14th ND	17
Dispensary, Naval Air Station, Pearl Harbor	28
(Ford Island, Additional Beds in Casualty Station)	10
Dispensary Submarine Base	54
Dispensary Navy Yard	0
(Available but not in use, Casualty Station)	207
Dispensary, Camp Catlin	30
Dispensary Cargo Handling Group	24
Ship Repair Unit	16
Naval Medical Supply Depot	0
Dispensary Advance Base Reshipment Depot	7
Dispensary Naval Air Station, Honolulu	6
Dispensary Naval Ammunition Depot, Oahu	43
Dispensary Section Base, Bishop's Point	5
Dispensary Camp Andrew	5

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offers some difficulty. In the majority of instances they existed to serve the personnel of the naval units to which they were immediately attached. Some specialization occurred in their functions, according to the type of naval establishment which they served. At the large receiving station attached to the naval base, specialized problems associated with the mass checking of health of persons coming from and going to tropical areas engrossed dispensary personnel. Industrial problems, associated with the medical care of persons engaged in the hazards of industrial work, received more attention at the Navy Yard dispensaries throughout the War than at the other Hawaiian dispensaries. Naval air station dispensaries were primarily interested in the maintenance of "flight health" of air personnel.

The line of specialized dispensary care at Hawaii cannot be drawn too clearly, however. The average continental dispensary served only personnel of the unit to which it was attached. But in the Pacific, with the rapid influx of new personnel throughout the War, many dispensaries treated naval and Marine Corps personnel from

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	Dispensary Radio Stations, 14th ND	15
	Dispensary Rifle Range, Puuloa	20
	Dispensary Naval Air Station, Barber's Point	100
	Dispensary Marine Corps Air Station, Ewa	18
	Dispensary Naval Air Station, Kaneohe Bay	150
Hawaii		
	Dispensary Naval Air Station, Hilo	27
Kauai		
	Dispensary Naval Air Facility, Barking Sands	20
Maui		
	Dispensary Naval Air Station, Puunene	52
	Dispensary Naval Air Station, Kahului	24
Johnston Island	Dispensary Naval Air Station	51

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stations other than those to which the dispensaries were themselves attached. This was not in the interests of presenting a smooth, administrative picture, but was geared to providing quick, necessary medical treatment and diagnosis to military personnel and their dependents in the immediate geographic location. All generalizations, therefore, concerning classifications and specialization of dispensary care in the Pacific, in relation to personnel handled, must be subject to this consideration.

From an administrative standpoint, the U. S. Naval Receiving Station Dispensary, Navy, Number 128 (Pearl Harbor), offered a good opportunity for examination. This was commissioned on 19 August 1940 as an activity of the Fourteenth Naval District and functioned under the direct cognizance of the commanding officer of the Receiving Station. Above this command were the Commandant Navy Yard, Pearl Harbor, Commandant Naval Base, Commandant Fourteenth Naval District and Chief of Naval Operations. The receiving station dispensary was itself the administrative command for five other dispensaries in the area, one photofluorographic unit and one penicillin laboratory.[73]

The complement of the receiving station dispensary consisted of one captain, (MC), the senior medical officer, one

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73. Cumulative Historical Report, Dispensary, U. S. Naval Receiving Station, Navy, No. 128, p. 1.

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commander, (MC), one lieutenant commander, (MC), two lieutenants (jg), (MC), one pharmacist, two chief pharmacist's mates, six pharmacist's mates first class, 10 pharmacist's mates second class, 21 pharmacist's mates third class and 7 hospital apprentices first class.

The primary function of the receiving station dispensary was to render medical attention and emergency hospitalization to personnel permenently and temporarily attached to the receiving station at Pearl Harbor. Routine sick calls were held and periodic inspections made. With the increase in personnel handled by the receiving station, the dispensary saw corresponding expansion during the war years. The original two rooms of the dispensary were given up in March of 1942 in favor of new quarters in a former decontamination building, and included a treatment room, large operating room, office space, consulation room, and two small medical storerooms. Frequent loans of personnel and equipment were made between the receiving station dispensary and the other smaller dispensaries under its direction.[74]

Two of the dispensaries under the administration of the senior medical officer of the naval receiving station dispensary were the dispensaries at the naval receiving station barracks, Dispensary

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74. Ibid., p. 3. These included Dispensary Area F, Dispensary Navy No. 10, Honolulu, SPU Dispensary, Wave Barracks Dispensary, Moanalua Ridge Dispensary.

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Area F. These were opened in January of 1943 and August 1944 respectively. Both dispensaries operated with the same medical personnel. In July of 1943, the barracks medical complement included 6 medical officers and 38 enlisted personnel. On 1 July 1944, the enlisted personnel had been increased to 49, while on 1 July 1945 there were 9 medical officers and 90 enlisted Hospital Corps personnel.

The two dispensaries rendered medical care to an average complement of 15,000 men, the large majority of whom were transients en route or returning from naval stations in the Central or South Pacific.[75] In addition, the medical department of the receiving station barracks acted as an emergency station for Frupac, Jicpoa, naval supply depot and the Fire Fighting School personnel.

The types of services rendered by the two barracks dispensaries were varied. Dispensary Number 1 provided medical care for the complement of the station, provided for transfers to naval hospitals, physical examinations, making duplicate health records for survivors from combat zones, annual physical examinations, physical examinations for promotions, inoculations, sanitary inspections, and radium plaque, in addition (during 1945 and 1946) to physical examinations on persons eligible for discharge under the point system. Barracks Dispensary Number 2 was designed

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75. Cumulative Historical Report of the Medical Department, U. S. Naval Receiving Barracks, Navy No. 10, p. 3.

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primarily to care for transient personnel. One of its main functions is the classification and reporting of all available Hospital Corps personnel to ComSerFor for assignment or transfer to other medical department activities.[76]

Medical facilities include a well equipped X-ray department. Dispensary Number 1 contains a 39-bed ward, a 4-bed sick officers' quarters, and a 3-bed isolation ward. Dispensary Number 2 maintains a 24-bed ward.

Dispensaries associated with an industrial establishment were best typified at the Navy yard in the Fourteenth Naval District. Again, however, specialization was only a part of the many services provided by the yard dispensaries. In 1941, the following classes of personnel received treatment by the medical department of the Navy yard:

1. Civilian employees of the Navy yard
2. Civilian employees of the District Public Works
3. Naval personnel of the Navy yard
4. Naval personnel of the District without other medical department facilities.
5. Marine Garrison Forces
6. Dependents of Navy yard and District service personnel
7. Emergency treatment of all personnel.

Caring for the seven classes of persons at the yard dispensaries were a main dispensary and medical department headquarters in Buildings Number 140 and 140-A, an Industrial Health Section

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76. Ibid, p. 4.

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(Organized in August 1941) and branch dispensaries at the Naval Radio Station, Wahiawa, and old Naval Station, Honolulu. To meet the increase in Civil Service employees and naval personnel, a main first-aid station was established in 1942 in Building 451-K. It was manned by two hospital corpsmen and a nurse and provided 24-hour emergency treatment.

By January of 1944, the activities of the Industrial Health Section had increased to a point where separate building facilities were necessary. Special laboratory equipment was installed to facilitate the evaluation of health hazards, performance of chemical and clinical tests wherever necessary, and the making of industrial surveys. Both an industrial health officer and a medical officer were assigned to industrial medical duties, and close liaison was established with the yard safety engineer.[77]

As in most of the Fourteenth Naval District medical activities, careful attention was paid at the Navy yard to the establishment of gas decontamination centers. Equipment was made ready, persons assigned, and bills of instructions drawn up to prepare for a Japanese attack with any of the many varieties of gas warfare. Seven casualty dressing stations and gas decontamination sections were spread throughout the yard and functioned under the administration of the yard medical officer as a part of the dispensary organization.

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77. Cumulative Historical Report of the Pearl Harbor Naval Ship yard, p. 3.

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Dispensary care for personnel of the fleet arriving in Hawaii was, for the greater part of the War, carried on by dispensaries in the Navy yard or at the receiving barracks. The administration of their care while at sea was a specialized problem, however, and in August 1944 an Administrative Center for Commander Cruisers, Destroyers, Destroyer Escorts, Pacific Fleet was established on Pearl City Peninsula, Oahu, with its own medical component and dispensary.[78] From this center, "Underway" medical officers were sent out by air to board destroyer escorts not carrying regularly assigned medical officers. Two medical officers and one dental officer, with a complement of 11 pharmacist's mates, operated the dispensary at the center. A complement of some 1,000 to 1,100 men and officers was served in this manner. Cases needing hospitalization were transferred to one of the three naval hospitals on Oahu.

Naval air stations and bases in the Hawaiian area and their dispensary facilities were under the command of the Commandant Naval Air Bases, Fourteenth Naval District and the Commandant Fourteenth Naval District throughout the War. The primary function of the air base, at Hawaii, as at all naval shore stations, was the support of the fleet.[79] This was achieved in several ways. Air stations at Hawaii not only serviced Pacific Fleet air personnel

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78. Cumulative Historical Report, Commander Cruiser, Destroyer, Destroyer Escort, Administrative Center, Pacific Fleet, p. 1.

79. Cumulative Historical Report for the Period of World War II, Naval Air Station, Kaneohe.

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and equipment, but also trained new personnel, and acted as funnels through which aviation personnel were sent out to Pacific islands for mainland. Their dispensary facilities were thus geared to several tasks.

The war history of Naval Air Station Navy Number 14 (Barber's Point) offers a good example for a study of an air station dispensary in action during the Pacific war. Ground had been cleared for the Barber's Point station in October 1941, but the station was not commissioned until 15 April 1942. From this time on the account was one of increasing expansion until the end of hostilities. The complement changed from 256 officers and men to 11,300 officers and men. The purpose of the station was provided for specialized training of flyers, ordnancemen, radio and radar technicians, mechanics, and maintenance crews in addition to servicing fleet air units and repairing and modifying aircraft from many of the large carriers.[80] The dispensary facilities were adapted to medical care of the station personnel attached permanently and temporarily to the station.

The dispensary at the Barber's Point Air Station was under the immediate command of the senior medical officer of the station, and was under the supervision of the Medical Officer, Commander Naval Air Bases, Pacific Fleet, and the District Medical Officer, Fourteenth Naval District.

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80. Cumulative Historical Report for the Period of World War II, Naval Air Station, Navy No. 14, p. 1.

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The station dispensary was opened August 1942, with a staff of 10 corpsmen and 1 medical officer. Eight double bunks, a dressing station, dental space and clerical office were provided. By April of 1943, the need for larger facilities had resulted in the commissioning of a new dispensary in a separate building with seven wings. The new quarters contained a 60-bed ward, receiving and laboratory rooms, surgical operating rooms, SOQ with 14 rooms, a 7-unit dental department and administrative space. Additional Quonset hut wards were added in February 1944, giving a 150-bed total. Nurses and Hospital Corps WAVES were added to the staff in 1944 and 1945.

Special techniques were designed at the dispensary for the care of pilots and personnel injured in plane crashes. A crash emergency room, combining surgery, plaster room and surgical ward plaster room and surgical ward isolation room, was developed to provide treatment and nursing care with the minimum of movement for the patients. This resulted in the most prompt and efficient care possible for the frequent cases of crash victims on the field.[81] In addition to treating an average of 85 bed-patients a day, the dispensary personnel furnished a medical officer of the day for the field and conducted regular and frequent checks on the health of personnel attached to the station.

In the over-all picture, dispensaries in the Hawaiian area,

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81. Ibid., p. 7

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after the 7 December bombardment had passed into the background, functioned as rear line medical aids. They came in little contact with actual battle casualties. Wounded who were brought back to Hawaii for further medical treatment received care at the great Pearl Harbor hospitals, not at dispensaries. Their functions were largely routine in nature, and while they were expanded and were in some instances created to meet medical needs in the Hawaiian area, the conditions coped with in the main were those present at continental naval dispensaries.

Advanced Base Dispensaries - Service Forces

In contrast to the relatively permenent dispensaries that existed at Pearl Harbor during the War were the advanced base dispensaries which were set up on captured Pacific islands often even before the fighting had ceased. Frequently, they were part of specific service units that were sent out to the Pacific to service other naval and Marine Corps units in action. In other instances they were attached to island commands, and gave medical aid to garrison forces and to a variety of other personnel on the island, including natives.

The advanced base dispensaries differed from rear echelon dispensaries in that the services performed were generally of a wider nature than those at Hawaii. Often there were no hospital facilities, except at a great distance, and in these cases the

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dispensaries rendered primary medical treatment and provided hospitalization for long periods. In addition, they coped with health and sanitation problems that were almost entirely absent at Pearl Harbor. In the Melanesian jungles, in the devastated areas of the Philippines, at Saipan, Iwo Jima and Okinawa they were set up in a loosely linked chain over the Pacific.

"G" Components

The advanced base dispensaries orginated in what were known as functional G components. These were actually field medical units, some mobile in character, and were known by such names as "Roses", "Lions" and "Cubs". One distinction in the types of G components sent out to the Pacific was in number of beds carried; but other G components were specialized units trained and equipped for a particular medical task. The following list defines the numbered G components and gives their cost of construction:

G-2	600-Bed Dispensary	$116,436.88
G-4	200-Bed Dispensary	44,810.13
G-5	100-Bed Dispensary	30,403.61
G-6	100-Bed Dispensary (Mobile)	14,883.03
G-7	50-Bed Dispensary	17,221.31
G-8	25-Bed Dispensary	8,857.97
G-9	10-Bed Dispensary	5,658.93
G-10	10-Bed Dispensary (Mobile)	3,206.94
G-11A	First Air Sub-Dispensary	243.72
G-13	Sub-Dispensary-Dental	2,142.82
G-14	Sub-Dispensary-Dental(Mobile)	1,641.94
G-15	Sub-Dispensary-Dental Prosthetic Lab	5,469.98
G-16	Sub-Dispensary-Dental Prosthetic Lab.(Mobile)	2,837.38
G-17	Malaria Control Component	581.73
G-18	Epidemiology Component	1,754.41
G-19	Malaria and Epidemic Control Component (1 G-18 plus 2 G-17's)	2,917.87

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G-20	Optical Repair Component Base Type	10,996.80	
G-21	Optical Repair Component Mobile Type	2,636.00	
G-22	Rodent Control	379.35	82

From this list it can be seen that some G components were not actually dispensaries.

The G components were conceived in 1941, developed in the experimental stage largely in 1942, and were assembled and sent out to Pacific islands beginning in 1943. This development coincided with the change in emphasis in the Pacific from a war of American defense to a war of American offense. Most of the G components were embarked from Port Hueneme, California, although some, in the later years of the War, were prepared in the Hawaiian area. In many cases, after their arrival at a designated post, the dispensaries were expanded to several times their original bed capacities, and in some instances developed into base hospitals. This frequently experienced rapid growth, often far in excess of original estimates and plans, coincided with the great influx of personnel at outlying bases in preparation for further campaigns. An examination of some of the types of G components that participated in the Pacific war will serve to clarify their status in the naval medical network.

The Advanced Base Naval Dispensary

One of the naval facilities which utilized the G components

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82. Historical Sketch, United States Naval Supply Depot, Brooklyn, dated 10 Nov. 1945.

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was the advanced base naval base dispensary. The setting up of service facilities in the form of naval bases and naval operating bases followed rapidly upon the wake of successful invasions in large island areas. Saipan in the Marianas Islands, developed into Naval Base, Navy Number 3245. The original medical personnel who were to become the naval base medical department landed eleven days after the invasion day on a beach north of Charan Kanoa. This medical group, part of GROPAC 8 (Group Pacific 8), was supplemented a few days later by a second medical echelon, and both set up a dispensary while the Japanese resistance was still in progress. Their work supplemented that of the amphibious force medical units which operated directly with the troops. In addition, they started a program of sanitation.

Gropac 8 was commissioned as a naval base three months later on 1 October 1944, with an average strength of 1,950 men which by 1 January 1945 was expected to reach 12,000. To provide medical care for these men, the G components were sent in, one (a G-6 unit complete with personnel) arriving 10 November and the other (a G-4 unit, minus personnel) arriving 1 January. Utilizing the medical facilities, three dispensaries were set up at the Saipan naval base. The main dispensary, located in the naval housing area, served an average of 250

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patients a day. One of the two remaining dispensaries served 750 colored troops, on sick call only, while the other operated directly at the port dock for Merchant Marine and small craft personnel. By April 1945, the naval base main dispensary had been moved to a new area and operated a 200-bed capacity (500 by 1 May). It served not only the naval base activities (Naval Supply Depot, AATC, CG Maintenance Unit, and Small Boat Repair), but also all island naval and Marine Corps activities and ships in the harbor.[83] In some respects the functioning of the Gropac medical units during the early phase of their arrival left something to be desired. Medical supply was a very real problem. Supplies sent with the Gropac units were inadequate and were early exhausted. For the most part supplies had to be secured from the Army General Hospital 148 on Saipan, and liaison with this body was most efficient.

At another naval operating base, Okinawa, seven G-10 components were utilized to provide dispensary service for the garrison forces and operated to 21 June 1945 when their mission was completed. Seabee personnel who arrived shortly after the combat phase was over carried with them their own medical components. The original G-10 components were replaced throughout succeeding months by the following medical units:

Component	Assignment
G-8 No. 16	Naval Supply Depot, Tengan

83. Cumulative Historical Report, Navy Base No. 3245 Dispensary (Saipan Naval Operating Base), p. 2.

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G-8 No. 29	Ship Repair Base, Baten Ko (East Side)
G-8 No. 36	Naval Base, Buckner Bay, Baten Ko (West Side)
G-8 No. 37	Naval Receiving Station, Kuba Saki
G-9 No. 4	Landing Craft Unit, Katchin Hanto
G-9 No. 10	Naval Base, Naha
G-9 No. 17	Naval Facilities, Bisha Gawa
G-9 No. 23	Naval Base, Chimu Wan
G-9 No. 39	Naval Ammunition Depot, Chimu Wan

The Okinawa G components were not required to treat campaign wounded except in the very early hours of their arrival. The Special Augmented Hospitals, making their first entrance into Pacific warfare in this campaign, took on much of the medical and surgical burden of campaign casualties.

At the Subic Bay Naval Base, established in May 1945, the orignal dispensary facility was a G-6 component with 100 beds. This dispensary struggled with the difficulties that many advanced base dispensaries in tropical island regions recently under combat were forced to meet. Low priority assigned to construction for medical facilities was one of the chief causes of trouble.[84] The result was the carrying on of "a large volume of medical work in a filthy, practically impassable morass during the rainy season, while at the same time an elaborate officers' club was built and operating."[85]

The most effective part of the dispensary work was a

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84. Cumulative Historical Report Medical Activities U. S. Naval Base, Subic Bay, P. I., p. 23.

85. Ibid.

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program of preventive medicine and malaria control. No epidemic disease of any kind broke out, and malaria cases were kept to a surprising minimum in a region in which malaria was endemic. The new naval base dispensary was put into operation on 28 August 1945. Personnel of newly arrived G components were pooled and distributed about the base area according to the local needs. Thus by the close of the War, the Subic Bay base was just able to set up good medical order.

A good story of the career of a G-4 component is seen in the unit sent to Tacloban, Leyte, in the Philippines. Ten officers and 40 enlisted men headed by a captain, (MC), were embarked with the supplies for a G-4 dispensary in March of 1945 from Treasure Island, California. It arrived in the Leyte-Samar area 10 April, and was followed by its second echelon arriving 31 May, and consisting of 2 officers and 133 enlisted men. The site for the dispensary (selected before the arrival of the G-4) was located near the Naval Shore Facilities at Tacloban, Leyte. Again, a low priority was assigned to the construction, and work was not begun until the end of June. The facilities were completed on 1 September 1945, and included 14 buildings of Quonset hut structure.

The administration of the unit was designated by the C.N.O.B., Leyte Gulf, as a separate command. The staff functioned

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smoothly, and morale, once the unit was set up, tended to be high.[86] The facilities included administration offices, first-aid and sick call room, EENT clinic, pharmacy, laboratory, morgue, storerooms, X-ray room, operating rooms, urology room, surgical, medical, and dermatology wards, and SOQ.

Medical Department inspecting parties which visited the facility on several occasions commented favorably on the "establishment and functioning of the activity."[87]

Construction Battalion Dispensaries

An important part of the Service Forces Pacific were the Seabee units which were brought directly into combat areas, frequently while fighting was in progress. The conditions under which they worked in hot, tropical climates, the types of heavy construction labor which they performed, and the greater age of the average Seabee resulted in medical problems for Seabee dispensary care.

Seabee units were attached to many types of administrative authority throughout the War, and as they were mobile in nature, the operational chain of command was frequently changed as they progressed from base to base. USNCB 95, when at Apamama in 1943, was attached to ACORN 16, and reported through the senior medical

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86. Report on the Establishment of G-4 Component No. 6 at Tacloban, Leyte, P. I., p. 3.

87. Ibid., p. 4.

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officer of that unit. When Number 95 moved to the Marshalls it reported through the island commander, and the island medical officer.[88] From a basic administrative standpoint, however, dispensaries attached to Seabee units were under the Commander Service Forces, Pacific Fleet.

Size of the construction battalions varied somewhat, but the average complement was about 1,100 men and officers. The average medical unit consisted of 2 to 3 medical officers, 1 or 2 dental officers and 7 to 12 hospital corpsmen.[89]

Especial emphasis was placed upon prevention of venereal disease, insect borne diseases, food infections and occupational injuries. Medical officers made weekly sanitation inspections of all work projects, in cooperation with safety engineers. Mosquito control squads were sent out from the dispensaries to reduce the possibilities of malaria infections. Serious casualties or cases requiring long hospitalization or surgical care were transferred to mobile hospitals or large G components in adjacent areas. Frequent observations were made by reporting medical officers regarding the relatively good ability of men of an older age group to adapt themselves [illegible]

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88. Historical Supplement to the Annual Sanitary Report, USN Construction Battalion No. 95, 1944, p. 10.

89. These figures are only approximate, and are taken from a compilation of historical data reports of C B battalion in the Pacific, on file at the Bureau of Medicine and Surgery.

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to the rigorous conditions of work and climate.[90] Dengue, malaria, skin infections, tropical ulcers and intestinal disease accompanied most of the Seabee battalions in the tropics. Occasionally medical disabilities afflicting older men occurred, and such cases were transferred to naval hospitals and sent back to rear areas.

Advanced Base Dispensaries - Air Forces

Dispensaries operating with naval air units in the Pacific were intended to assume an organization native to the type of activity they served. Actually, as in other advanced bases, they served many other naval units and personnel in their vicinity.

One of the advanced base units serving naval and Marine air facilities was the CASU (Carrier Aircraft Service Unit). This was a relatively mobile unit utilized in advanced air bases. To care for the health of the men in a CASU, each unit carried its own medical and dispensary facilities. The extent of the dispensary facilities and activities varied. CASU 11 at Espiritu Santo, arriving in the mud and rain of a March storm, set up service in a pyramid tent, one box serving as a treatment table. The medical officer assigned to the unit had

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90. Historical Data Supplement to the Annual Sanitary Report, U. S. Naval Construction Battalion 37, 1943, p. 14.

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been invalided and detached before the CASU was landed. In his absence, the dental officer and six corpsmen carried on the duties of the dispensary until the beginning of April when two naval medical officers reported. The dispensary, flooded by rain, inundated by malaria cases which had to be treated in their tents, and bombed by the Japanese "Washing Machine Charlies", as the noisy enemy planes were called, carried on valiantly giving medical treatment to the CASU's complement of 588 men and officers. Serious cases were sent to Army hospitals and later to the naval mobile hospital on Espiritu.[91] CASU's tended to be near the lines of combat more than other advanced base units. Their personnel were landed, and began servicing rough new air strips almost during the campaign, while Japanese bombers made air strips their especial interest.

Some forward areas to which CASU's were sent were free from enemy attack or bombing. In such cases it was much easier for dispensaries attached to these units to perform their medical duties. CASU 30, arriving at Majuro Atoll in the Marshalls in February 1944, was able to set up its facilities quickly and was never bombed by the enemy.[92] During flight operations a medical officer, corpsman and ambulance, from the dispensary,

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91. Annual Sanitary Report of CASU No. 11, 1943.

92. Historical Data to Annual Sanitary Report, CASU 30, 1944.

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stood by on the air strip to give medical aid to flight personnel if necessary. In addition, daily sick call was held; patients averaged from 10 to 15 percent of the total complement (642 persons). The most common complaint was fungus infection of the feet, hands and ears. This complaint accounted for about 50 percent of all visits.

A second type of dispensary facility serving air units was the ACORN dispensary. ACORN's were a more permanent type of unit serving naval air facilities at advanced bases, and tended to be larger in number and medical staff than the CASU's. They utilized the G components for their physical setup, and in practice gave a much wider type of medical service than did the CASU's.

ACORN 24 was landed at Los Negros in the Admiralty Islands in April 1944, and by 15 May had established a 160-bed dispensary. Their patient load came mainly from Navy air activities on Los Negros and from adjoining Marine and Army camps.[93] This is illustrative of the diversified nature of patients served by advanced base dispensaries, even when they were as specialized as were ACORN dispensaries. ACORN 24 dispensary was filled to capacity from the time of its opening, as it was the main naval medical facility in the immediate area until

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93. Historical Summary for the Decommissioning and Quarterly Sanitary Report, 1945, ACORN 24, p. 6.

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Base Hospital Number 15 was commissioned on Manus in July 1944.

Medical cases included the ever-present fungus infection, and also 21 cases of tsutsugamushi disease which were treated in an isolation ward. In addition, battle casualties from the invasion of Peleliu in September of 1944 were received at the dispensary, chiefly for screening to determine whether further evacuation was necessary. As many as 190 patients were unloaded at the dispensary within a fifteen minute period. The wounded from the Philippine invasions also were treated and hospitalized at the ACORN dispensary later in 1944 and during 1945. From March of 1945 the work of the dispensary decreased, as the air squadrons served by the ACORN were detached. A separate medical facility for transients had also been set up at the Transient Camp, Momote Air Field, and in September 1945, ACORN 24 was decommissioned.

The operation of another of these naval air medical facilities can be seen in the report of ACORN 13 at Bougainville. This facility's primary mission was to keep Torokina Air Strip and its personnel in efficient operating condition. A 100-bed dispensary was operated at ACORN 13 by 6 medical officers and 54 corpsmen. This number, however, was reduced early in 1944 to three medical officers and 44 corpsmen. A lieutenant commander, who was also a EENT specialist, acted as flight surgeon and kept a

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careful check on flight personnel at the air strip. Medical care was available at the ACORN dispensary to approximately 1,500 personnel, including Navy, Army, Marine, and New Zealand military personnel, and native work parties. In addition, an important aspect of the ACORN medical department's work was the maintenance of proper sanitation in the area. Other problems also plagued ACORN 13 personnel. Japanese bombing raids were frequent (averaging two a night) in the beginning of 1944, but tapered off after February. During the months of enemy attack first-aid stations and evacuating units were manned by ACORN 13 dispensary personnel.

Part of the medical program conducted by the ACORN 13 dispensary was the performance of "complete physical and psychoneurotic examinations with appropriate treatment" on officers and enlisted personnel attached to the ACORN.[94] Persons found unfit for duty were transferred to a fleet hospital for further treatment and disposition. Tetanus toxoid, typhoid and smallpox vaccine were administered to all personnel, and vigorous campaigns against fungus and malaria infection carried out. A blood bank was established and a list of potential donors drawn up.

The majority of the ACORN's were assembled at the ACORN Assembly Training Detachment, Port Hueneme, California. When

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94. Historical Data Supplement to the Annual Sanitary Report, USN ACORN 13, 1944, p. 15.

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they left the United States they came under administrative fleet air command. The senior medical officer of ACORN 48 at Mactan Island, in the Philippines, was under the following administrative chain: Commanding Officer, ACORN 48, Commander Naval Air Base, Mactan Island, P. I.; Commander Naval Air Base, Samar, P. I.; Commander Air Forces Seventh Fleet; Commander Seventh Fleet; Navy Department Washington.[95] Frequently ACORN's were expanded into naval air bases, and in such cases dispensary facilities were correspondingly expanded.

Dispensaries manned by naval personnel were also attached to Marine fleet air wings, groups and squadrons at advanced Pacific bases. Medical officers assigned to these units were chiefly concerned with maintaining the health of flight personnel. However, at bases where medical facilities were few, their activities included care of nearby ground based personnel, care of commercial air pilots, maintenance of a sanitation program, and care of transcient personnel. From an administrative standpoint, the chain of responsibility ran from squadron medical officer to group medical officer and wing medical officer. Considerable independence of medical action in dispensaries attached to the three groups was practiced, however, in the combat areas.[96]

In Marine Aircraft Group 31 (MAG 31), for example, the

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95. Cumulative Historical Report for the Period of World War II, ACORN 48, p. 2.

96. Historical Data Supplement to the Annual Sanitary Report, Headquarters Squadron, 2nd Marine Aircraft Wing, 1943, Navy No. 156, p. 1.

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average squadron medical department consisted of one flight surgeon or aviation medical examiner, and eight (later reduced to four) corpsmen. Each squadron had its own dispensary facility, and above this was the larger Group Medical Department with its dispensary facility.[97] While at Roi Island, MAG 31 in March 1944 put a 12-bed group dispensary into commission, complete with surgery, pharmacy, laboratory, dental office, ward, X-ray, EENT room, and clerical office. No hospital facility was located on Roi; the only other medical facility being a dispensary at the naval operating base. As a result, all forms of minor surgery (appendectomies, herniotomies, etc.) were performed at the MAG dispensary. Personnel requiring more treatment than permitted by the dispensary facilities were flown back to Pearl Harbor.

Dispensary medical personnel attached to Marine fleet air units made every effort to supervise not only the physical condition of their pilots but also their general physical and emotional well-being. Pilot fatigue received especial attention. Their other medical problems were routine in tropical climates -- skin disease (usually fungus), malaria, and intestinal diseases.

Advanced Base Dispensaries - Amphibious Forces, Pacific Fleet

The Amphibious Force, Pacific Fleet, was organized on 10 April

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97. Cumulative Historical Report of the Medical Department Marine Aircraft Group 31, 1 Feb. 1943 to 30 Aug. 1945, p. 5.

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1942, Commander Scouting Force Pacific Fleet assuming the command.[98] The main story of the medical department of the amphibious forces is a part of the narrative history of amphibious corps units in combat in Pacific campaigns. This is the epic of the medical companies and battalions who accompanied the fighting dividions into the jungles and on to the shores of volcanic islands. There were, however, naval dispensaries which operated under the amphibious force command units attached to Fleet Marine Force shore facilities, including transient centers, training centers and service centers. In addition, dispensaries serving island commands operating under comphibfor were scattered throughout the Pacific.

Transient center amphibious force dispensaries had the problem of checking health and caring for sickness among combat personnel moving to and from combat areas. Their work was similar to that of the Hawaiian Receiving Station Dispensary, except that in many instances it was complicated by the more onerous physical conditions of advanced bases.[99] Service center amphibious force

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98. The Amphibious Force was made up of Amphibious Corps, Pacific Fleet, (Marines and attached Army personnel); Transports, Amphibious Forces Fleet; Landing Craft School, Amphibious Forces Pacific Fleet; and Amphibious Forces Pacific Fleet Communication School. At the end of the War, Amphibious Forces Pacific consisted of some 3,400 ships and landing craft of which 2,850 units had medical personnel attached. The total medical, dental, and Hospital Corps personnel assigned was about 1,500 officers and 8,500 enlisted men. Total personnel of Amphibforpac was about 330,000. Cumulative Historical Report for World War II, Commander Administrative Command, Amphibious Forces, Pacific Fleet, p. 3.

99. The purpose of transient centers dispensaries was defined as the

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dispensaries gave medical support to the service battalions which followed combat troops in the island campaigns. Amphibious force training centers were set up in Australia and large island areas. Their dispensaries provided medical care for men undergoing rigorous advanced physical training. Island command dispensaries under the amphibious forces furnished medical care to personnel attached to island commands. All of the amphibious forces were created by war needs, and their growth kept pace with the increase in military personnel assigned to Comphibforpac from 1942 until the end of hostilities.

The size of an advanced base training center dispensary can be seen in the report on the Amphibious Training Center, Toorbul Point, Queensland, Australia. Its site was a low swampy point of land which projected into Moreton Bay, and offered numerous problems of sanitation. In this area, by 1943, a very small dispensary had been built up to a 35-bed unit.[100] Another amphibious force training center dispensary at Port Stephens, N.S.W., was established in February of 1943, and supported 50 beds. As the focus of the War changed, many training centers and their dispensaries were moved or decommissioned to meet

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maintenance of the health of their own commands, determining "that all men going into combat areas were physically fit and had been properly immunized," and determining "that all men returning from combat areas were physically qualifies for duty... limited or combat duty." Cumulative Historical Report World War II, Medical Department Transient Center, FMF, Pacific, n. p.

100. Historical Data Supplement to the Annual Sanitary Report, Seventh Amphibious Force, 1943, p. 1.

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The Service Battalion, Third Amphibious Corps, operated on Guadalcanal and Guam during 1944. It maintained a small dispensary, laboratory and surgical room for minor surgical cases. Two medical officers and one dental officer operated its facilities with the assistance of 23 hospital corpsmen.[101] The complement of the organization to which the dispensary was attached varied from 1,800 to 2,200. Chief medical problems were skin disorders, ear infections, catarrhal fever, malaria, dengue, minor orthopedic complaints, gastro-intestinal complaints, and minor surgical cases. The U. S. Naval Fleet Hospital Number 108 cared for patients whose needs required more treatment than the service battalion dispensary could render. The dispensary facilities were organized into a combat emergency battalion aid station from 1 June to 15 August 1944, while the battalion participated in the invasion of Guam. The station, however, was actually only in operation for 24 hours during this period, since most of the fighting was over by the time the battalion was landed.

Naval dispensaries in the Pacific during the years of World War II were subject to a great process of growth and adaptation. The needs, resulting from a new type of island warfare, fostered the creation of the G component dispensaries.

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101. Historical Data Supplement to the Annual Sanitary Report, Headquarters and Service Battalion, Third Amphibious Corps in the Field, 1944, p. 13.

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The establishment of new service and operational units brought about new systems of dispensary care. The problems of sanitation, supply, and health of personnel, to which the dispensaries were subjected by reason of climate and terrain, presented many difficulties to medical officers and Hospital Corps men. Adaptability became one of the primary considerations in setting up new dispensary units. Following August of 1945 there occurred a period of decrease in activity of some advanced base dispensaries. Others, in the Fourteenth Naval District and at transient centers, received a great influx of activity as personnel were funneled back to the United States. In performing their routine duties, meeting emergencies as they arose, and carrying out the policies of the Navy Medical Department, Pacific dispensaries performed a vital and necessary task throughout the War.

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CHAPTER XV

MEDICAL INSTALLATIONS IN THE ATLANTIC AREA

Section 1 Introduction

American medical installations in the Atlantic were largely confined to the Western Hemisphere and to Western Hemisphere defense when Pearl Harbor was attacked in 1941. There were medical facilities in the West Indies, the Canal Zone, a few of the bases which had been leased from Great Britain and even a small dispensary as far removed from our mainland as Iceland.

When war broke out in Europe our immediate defense problem was to strengthen our ramparts stretching from Iceland as far south as Trinidad. The U. S. Naval Mobile Base Hospital Number 1 had been established at Guantanamo Bay, Cuba, 30 October 1940. Medical units were provided at the naval radio stations at Cape Mala, Summit and Balboa in the Canal Zone. Dispensaries were caring for the sick and injured at the Naval stations in Guantanamo Bay, Cuba, and at the naval operating bases in Balboa, Canal Zone, and Bermuda by 1941. United States naval medical treatment was being administered at various Fleet Marine Force detachments in St. Thomas, Virgin Islands, as early as 1939, and at Guantanamo Bay, Cuba, as early as 1940; and by 1941 establishments had been set up to provide this care to Marine Brigade detachments in Iceland;

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Bermuda; Portland Bight, Jamaica, British West Indies; Antigua, Leeward Islands; St. Lucia Windward Islands; Georgetown, British Guiana; and Roosevelt Roads, Vieques Island, Puerto Rico. The ninety-nine year lease which we acquired to many of those outlying posts had developed our defense obligations. United States naval bases at Coco Solo, Canal Zone, and St. Thomas, Virgin Islands, also section bases at San Juan, Puerto Rico, and Cristobal, Canal Zone, had small medical establishments. Similarly, facilities had been provided to administer medical care to naval personnel attached to the naval ammunition depot at Balboa and the naval net depot at St. Thomas, Virgin Islands, as well as the naval air stations at San Juan, Bermuda; Guantanamo Bay; Trinidad, British West Indies; and Coco Solo.

The expanded development of the Atlantic medical installations forged ahead with the establishment of advanced bases which immediately followed the United States' entrance into the war against Nazi Germany. The United States Naval Base Hospital Number 1 was commissioned at Londonderry, northern Ireland, February 1942, to service naval personnel of the naval base, the medical supply storehouse and the naval radio station at Londonderry. This was a very valuable asset to the personnel of American troop and cargo carriers en route to the Allied powers.

The first combat contact of this country with the enemy in the War was the naval bombardment of the shore installations and coastal fortifications in Casablanca, Oran and Algiers followed by

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the amphibious landings which brought naval personnel into the area, particularly into Morocco. The Navy Medical Department, following carefully drawn blueprints, immediately assumed its responsibility. The first patients for first-aid treatment were received in a camel barn. The first battalion aid stations were enlarged into medical units that later evolved into dispensaries. As our forces landed and moved inland into North Africa, the medical pattern was crystallized. Major dispensary units gradually developed at Oran, Port Lyautey, Arsew, and Bizerte, and the dispensary at Casablanca expanded into a hospital, U. S. Naval Base Hospital Number 5 - its increase in size resulting from the growing importance of Casablanca as a port of entry for American service personnel and as an evacuation center. Lesser dispensaries were established at Fedala, Safi and Agadir in French Morocco, and naval station sick bays of varying sizes were set up at Mers-el-Kebir, Algiers, Nemours, Beni Saf, Mostaganem, Tenes, Cherchell and Dellys in Algeria. By summer of 1943 it was obvious that a naval hospital of sufficient size was needed to treat and hold all naval personnel in the northwest African theater who were in need of proper medical and surgical care. This installation was essential to care for the personnel of the units of the U. S. Eighth Fleet based in the northwest African waters and to supervise the expanding medical activity within the actual theater of operations. Necessary steps were taken and U. S. Naval Base Hospital Number 9 went into operation in Oran in November 1943 with a possible bed capacity of 500.

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With the close of the Tunisian campaign all the amphibious training bases in Algeria except the one at Arzew were decommissioned and new bases were established in the Bizerte-Tunis-Ferryville area. The medical components to support the invasion of Sicily constituted a 50-bed unit destined for Palermo and smaller units for lesser ports of the south coast of the island. These satellite units were completely set up and in September 1943 all U. S. Navy activities in Sicily were consolidated at Palermo, the Naval Operating Base, where a nominal dispensary of 160 beds, functioning as a hospital, provided hospitalization for all naval personnel stationed in Sicily. This important installation was, later in 1944, supported by 25-bed dispensary units at Calvi, Basia and Ajaccio in Corsica and at Madallena Island in Sardinia.

As American forces advanced northward from the Italian boot it became necessary to provide a major dispensary at Naples, the largest and most important one in Italy, with a lesser facility at Salerno and a small dispensary at Rome serving as a rear medical station in the area. The most important installation in southern France, also located in the northwest African theater of operations, was the dispensary unit at Marseilles which was established after the Normandy invasion. Geographically, but not chronologically, it fits into the Mediterranean portion of the story of Atlantic medical installations.

As the year of 1944 opened, preparations for the Normandy invasion were well under way. Bases and sub-bases had been estab-

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lished at various ports including those at Londonderry, northern Ireland, and Rosneath, Scotland. There were two hospitals in the United Kingdom: U. S. Naval Base Hospital Number 1 at Londonderry Naval Operating Base and the U. S. Naval Base Hospital Number 12 located at Netley Hants, England. The latter, the only naval base hospital in England, was established primarily for the treatment of was casualties during the invasion. The largest dispensary in the United Kingdom, outside of England proper, was the 200-bed dispensary at Base Two, Rosneath, Scotland. There was a much smaller one at the radion station at Londonderry.

In preparation for the amphibious operations in the invasion of Normandy, medical facilities were completed at the base ports on the southern and south-western coasts of England with the Headquarters Dispensary of the Co mander, Twelfth Fleet, located in London. The port naval bases and sub-bases became the centers of the principal naval medical facilities in the United Kingdom. These were Plymouth, Saltash, Appledore, Falmouth, Fowey, Salcombe, Dartmouth, Teignmouth, Penarth and Milford Haven, St. Mawes, Poole, Portland-Weymouth, Southampton, Deptford, Exeter, and Calstock. They were the more important installations in England which had been completed or strengthened by additional beds prior to D-day.

After the invasion, small dispensaries were set up on the French beaches - more specifically, the naval advanced bases at Omaha and Utah Beaches. With the strengthening of our positions along the French coast and the movement inland of our forces,

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dispensaries were established at Cherbourg and Le Havre and later in Paris. Lesser medical units were interspersed in the surrounding area. Almost on the heels of the Allied crossing of the Rhine, medical department activities were established in Germany with 50-bed dispensary units at Frankfort and Berlin. A few were located at sites where excellent accommodations of German military establishments were available as at Bremen and Bremerhaven.

Western Hemisphere defense had laid the groundwork for the medical installations in this hemisphere. The major ones indicated at the outset were strengthened or expanded after the United States entered the world conflict. The medical installation at Reykjavik, Iceland, expanded into a hospital-dispensary. The U. S. Naval Mobile Base Hospital Number 1 had been dismantled and moved from Guantanamo to Bermuda 23 July 1941. The two naval hospitals in the Tenth Naval District, namely, the 200-bed naval hospital at San Juan, Puerto Rico, and the 300-bed hospital at Trinidad in the British West Indies, with the two naval hospitals in the Canal Zone, a 350-bed activity in Balboa, and a 400-bed hospital at Coco Solo, were supported by many dispensaries and minor medical installations scattered throughout the Caribbean area. These installations furnished emergency medical treatment to survivors rescued from ships that were torpedoed in the Caribbean and South American waters. These numerous dispensary facilities, sick bay installations, and first-aid stations within the environs of the Tenth and Fifteenth Naval Districts provided medical care and treatment

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and hospitalized all naval personnel attached to fleet training crews or naval shore bases and installations in those districts.

Section 2 Mediterranean:

Northern Africa, Sicily and Southern France
Medical Installations

The original United States Navy units that landed in North Africa in November 1942 brought with them dispensary personnel and equipment sufficient to provide dispensary care only for their complements. It was originally intended that they serve only as dispensaries, not hospitals. These units were established in Port Lyautey, Fedala, Casablanca and Safi in French Morocco and also in Nemours, Beni Saf, Oran, Arzew, Mostaganem, Tenes and Cherchell in Algeria. A small dispensary was placed in operation for the attached personnel when a United States Navy Headquarters detachment was established in Algiers.

Allied attacks at Fedala, Safi and Port Lyautey and the bombing attacks of units of the French fleet in the harbor of Casablanca were followed by amphibious landings at Fedala and Safi on 8 November 1942. Safi was taken early in the morning of the eighth; Fedala fell at noon of the same day and Port Lyautey was taken on 10 November. The city of Casablanca surrendered to our land forces around this same time after considerable resistance.[1]

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1. U. S. Base Hospital No. 5, Historical Data, 8 Nov. 1942 to 3 Jan. 1943.

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Prior to these actions the actual command of organizing the medical units engaging in the expedition against French Morocco had been entrusted to Capt. H. G. Sickel, (MC), USN, who was to work in cooperation with the United States Army and Captain Andrus, (MC), USN, of the Planning Division of the Bureau of Medicine and Surgery. Lt. Comdr. B. LaFavre, USN, was assigned to carry through the administrative organization of these medical units under the command of Captain Sickel. The work constituted providing the medical set-up of three separate units for the four projected bases in French Morocco.

Several weeks of concentrated effort culminated in the arrangement for and the delivery of the necessary supplies to the several ports of departure. These were classified according to the sequence of movement. The first echelon of the expedition set sail on 23 October 1942 from Norfolk, Virginia. The medical personnel for Port Lyautey expedition bases proceeded at a later date.

Two days after the landing operation had started, 10 November 1942, the first naval medical personnel, with Comdr. H. B. La Favre as the senior medical officer of the expedition, debarked at Fedala. The group constituted two other medical officers and eight corpsmen. A camel barn on the dock at Fedala was selected as temporary barracks for naval personnel and a small sick bay was set up in an adjoining office. The preceding afternoon of 9 November Lt. Comdr. Maurice T. Bates, MC-V(S), USNR, accompanied by one corpsman, debarked at Safi and established a first-aid station in the port area.

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The naval dispensary at Safi in the Regie Tobacco Company operated until the close of the base section there, 25 August 1943. The dispensary at Fedala went out of existence 10 September 1943 when the section base was closed. The medical personnel and equipment of these two activities were consolidated in Casablanca and Port Lyautey.

After the fall of Casablanca, Commander La Favre, with a medical officer and five corpsmen, was ordered to proceed thence. The first dispensary, converted from a large office and adjoining room, continued throughout 1943 to be the naval dispensary in this port area. The French Military Hospital agreed to care for any surgical emergencies in the early period, as our units had no surgical supplies--many materials had been lost in transit or sunk. The establishment of the unit at Casablanca as a permanent dispensary dates from 7 December 1942. At that time a former French physician's clinic had been secured. The building afforded space for 54 beds, and the medical and surgical units, complete with X-ray equipment, which were on hand permitted immediate functioning. This dispensary was honored by a visit from the Surgeon General, Vice Adm. McIntire, January 1943.

Gradually, the unit occupied neighboring villas resulting in the attainment of space for 210 beds. As a consequence of its increased size and also as a result of the growing importance of Casablanca as a port of entry for both Army and Navy personnel as well as an evacuation center for casualties returned to the United States,

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this naval dispensary at Casablanca was designated as Naval Base Hospital Number 5 on 5 August 1943. The hospital was under the command of Captain La Favre, (MC), USN.

The distribution of medical supplies to United States Navy activities within the North African theatre was carried out expeditiously by Naval Medical Storehouse Number 9, established in Casablanca 5 May 1943. Amphibious craft, too, could draw for current replacement in small amounts from this fairly well-stocked storeroom.

Naval Base Hospital Number 5 comprised four buildings built of fire resistant stucco construction. With one exception, namely, the surgical building to which former reference has been made, all these buildings were dwellings or villas leased by the Government. This surgical building had formerly been a small private hospital. In addition to the four main hospital buildings there were six Quonset huts erected in the yard at the rear of the buildings, four of which were used as quarters for hospital corpsmen.

The sanitary reports for the hospital indicated that the facilities of the medical department were generally adequate considering the amount of work handled. Ordinarily, isolation of infectious and communicable diseases presented no problem.

The hospital doctors complained frequently of the lack of essential drugs and materials needed for adequate modern therapy. Some

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items were never attained; others were brought in at irregular intervals and still others in insufficient amounts. The cooperation of the Army medical units in this respect was opportunely helpful. The Army's supplying a large quantity of penicillin at one time proved to be a real lifesaving boon. The Army hospital equipment and hospital rooms were an excellent supplement to the autopsy facilities at the hospital.

Adequate standards were maintained for staff, enlisted personnel, equipment, instruments and accommodation for patients for the type of surgery performed at this activity with the exception of orthopedics where a qualified surgeon was needed and thoracic surgery which was destitute of the proper anesthesia equipment.

The volume of work of the neuropsychiatry department was small. The greater number of patients who passed through this service were transferred to the United States for disposition on the ground that they were unfit for duty in this theatre of war. The rest were mental disease suspects, psychoneurotics or patients suffering from neurological disorders of various types.

This hospital rendered dental treatment, both operative and prosthetic, to the hospital staff and patients, to the Naval Operating Base, Moroccan Sea Frontier, and to the American consulate. Emergency dental treatment was given to personnel of American and United Nation ships entering the port of Casablanca.

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Venereal diseases constituted almost 80 percent of the admissions to the urological service. Urologic diseases of non-venereal nature and dematological diseases were also handled by this department. By the end of 1943 a supply of penicillin was on hand for the treatment of sulfa-resistant gonorrhea.

There were no epidemics among the Hospital Corps personnel. Hospital admissions were most numerous from the epidemic diseases: acute catarrhal fever, tonsillitis, acute jaundice and gonococcus infection. Malaria was not a problem in Casablanca either among base or hospital personnel. Gonococcus infections were high among naval personnel generally but low among the hospital personnel group. There were slight epidemics of diarrhea among the base personnel occasionally but they didn't extend to the hospital personnel. The excellent housing conditions at the hospital resulted in a low incidence of respiratory infections.

The water supply was good but drinking water was chlorinated at either the source or somewhere along the supply route, because generally poor plumbing in the area and frequently broken conduits were always considered a potential source of contamination.

During the peak year (1943) of the history of this hospital, there were 21 officers and 104 enlisted personnel attached to the staff. By 1944 the officer personnel had been reduced to 15 and the enlisted men had been cut to 84. There were no members of the Navy Nurse Corps attached to this command. The rotation of duty for hospital corpsmen,

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in so far as possible, was to insure a complete training program for advancement in rating. This was an important contributory function to the high morale of the crew.

In the fall of 1943 a naval air station was established at Agadir, French Morocco. The personnel to man it were brought from the United States and the equipment for this 25-bed dispensary was obtained in the theatre itself.

The naval dispensary at Port Lyautey took over a wing of a small civilian hospital anf functioned actually as a naval hospital on a small scale from the beginning.

At a later date, 7 April 1944, the U. S. Naval Air Station Dispensary, Port Lyautey, French Morocco, was established as a U. S. naval air facility for seaplane activities under the administrative control of the U. S. Naval Air Station, Port Lyautey. This medical activity was concerned with the health of personnel on duty at the station, with two exceptions - the responsibility of the station for spraying the Pan-American World Airways Clipper on arrival and in departure and for instituting safety measures involving the dispatch of passengers at the terminal.

Whenever necessary, the 93rd Army Station Hospital and later the 367th Army Station Hospital, U. S. Army, supplied the services of a medical officer. However, when both of those activities had been deactivated, the 125th Army Air Forces, North African Ferrying Division, Air Transport Command, maintained a 10-bed dispensary with three medical

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officers on duty.

The control of malaria thru the use of DDT was one of the most effective parts of the medical program at this activity. Thru this and other measures the entire program was a 100 percent protective agent for naval personnel.[2]

There was a small dispensary at headquarters at Dakar, French West Africa. It was set up for a sick bay only. All patients who required hospitalization here were cared for by the Army.

At the end of the Tunisian campaign all the amphibious training bases in Algeria except the Arzew base were decommissioned New bases were set up in the Bizerte-Tunis Ferryville area. The medical personnel and equipment from the decommissioned bases were used in various ways. Some were moved to Bizerte while others were consolidated in the remaining bases or used to strengthen and expand new activities.

Early in the summer of 1943 it seemed to be apparent that a naval hospital of sufficient size was needed in the Oran area. Some activity was essential to keep a better check on Navy patients and their records at the Army's main port of evacuation, also to prevent evacuation of Navy patients out of the theatre without the knowledge

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2. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for period of World War II of the medical installation at U. S. Naval Air Station, Port Lyautey, French Morocco, in files of Administrative History Section.

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of naval authorities. Permission to ship such a unit from the United States was obtained and a request was sent to CNO for a 200-bed hospital in Oran. Authorization for such a hospital was promptly granted.

Hospital Unit (Glen 57) was assembled and transported to the North African theatre, disembarking at Oran on 3 September 1943. A tentative site had been selected prior to the arrival of the unit and the projected bed capacity of the hospital had been increased from 200 to 500 beds. Two construction battalions started the actual building of the hospital 15 September 1943, and on 19 November 1943 the hospital was formally placed in commission bringing a 500-bed Quonset hut U. S. Navy Base Hospital into operation in Oran. It was designated United States Naval Base Hospital Number 9. At the time of its commissioning the staff constituted 19 medical officers, 4 Hospital Corps officers and 137 hospital corpsmen.

This hospital was a completely integrated unit containing within the compound every facility to form a self-sustaining unit for the medical care of all U. S. personnel in this area and personnel from all allied ships of war and maritime services. The activities which it serviced were many and they were spread over a wide geographical area.[3]

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3. Historical Data of U. S. Naval Base Hospital No. 9, Oran, Algeria, for Calendar Year 1945, in files of Administrative History Section. This hospital served the following activities: U. S. Naval Detachments in Marseilles, France (Navy 3110); in Toulon, France (Navy 3205); in Naples, Italy (Navy 728); in Ajaccio, Corsica, and in Oran, Algeria. U. S. Naval Stations in

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The patient census increased steadily from the commissioning day and reached the peak on 31 January 1944 with a total of 428. The total fluctuated from this point varying daily but remaining slightly below the peak number. Numerous air and sea evacuations resulted in sharp trends in the patient load.[4]

The hospital was almost ideally situated on the northeast slope of a ridge on Route Nationale Number Two, at Point Albin, almost six miles from Oran. Good communication to the port area was assured by means of the paved highway which the hospital grounds faced.

The hospital buildings consisted of 107 prefabricated quonset type huts of three different sizes. Sixty-four of these were large huts which were used as enlisted men's quarters, sick officers' quarters, staff officers' quarters and for bakery, galley, scullery, refrigeration, laundry and commissary stores housing.

Arzew, Algeria (Navy 232); in Oran, Algeria (Navy 147) and in Mers-el-Kebir(Navy 233); also, U. S. Supply Depot in Oran, Algeria, Navy (147); U. S. Naval Operating Base in Palermo, Sicily (Navy 157); Construction Battalion Maintenance Unit 626, 567, 1040 Bizerte; AATB Salerno, Sicily; Tunisia 1005, Bizerte, Tunisia; AATB, Bizerte, Tunisia, 1st, 4th and 8th Beach Battalions; U. S. Naval Air Station, Port Lyautey, French Morocco (Navy 124); 60th Station Hospital, Cagliari, Sardinia, 54th Station Hospital, Tunis, Tunisia, Western Town Command, APO 789; and Forces Afloat - All Ships in the area of Allied Forces and Maritime Services.

4. Historical Data of U. S. Naval Base Hospital No. 9 Oran, Algeria, for Calendar Year, 1945, in files of Administrative History Section. In Feb, 1944 there were 209 patients evacuated by sea to hospitals in the United States. The largest evacuation total in the history of the hospital occurred in Aug. 1944 when a total of 274 patients were evacuated, 135 by air and 139 by sea.

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These large huts also furnished administrative housing and medical overflow ward space, and two of them were set aside for Red Cross activities. The small huts were used as medical and surgical wards, operating rooms and laboratories. Lighting and ventilation were satisfactory. Three isolation ward huts, subdivided into cubicles, were provided for the care of communicable diseases.[5]

The average complement of medical officers on the service varied between three to five including the Chief of Medicine. They were assisted by 31 corpsmen who carried out the ward work. Navy nurses supplemented the staff from April 1944 to May 1945. The reports indicate that the service was adequately staffed at all times.[6]

During the period from the commissioning date of the hospital to 1 September 1945 there were 2,793 admissions to the medical service, and six deaths.[7]

Special studies were undertaken in the medical service and three papers were written by members of the staff and accepted for publication in U. S. Medical Bulletin.[8]

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5. Annual Sanitary Report of the U. S. Naval Base Hospital No. 9, Oran, Algeria, for Calendar Year 1943 in files of Administrative History Section, p. 3.

6. Annual Sanitary Reports of the U. S. Naval Base Hospital No. 9, Oran, Algeria, for the Calendar Years 1943, 1944, 1945 in the files of the Administrative History Section.

7. The peak load of patients was 252 to the medical service, the patient load for Dec. 1944; the total number of admissions to the hospital this particular month was 579.

8. Historical Data of U. S. Naval Base Hospital No. 9, Oran, Algeria, for 1945 in files of Administrative History Section. Titles were

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The facilities of the surgical department were established to accommodate approximately 250 surgical patients. In case of dire emergency, arrangements could be made to double that capacity. The peak load of the surgical service came in January 1945 when the highest daily census was 176. Hence the facilities of this service were never used to their full capacity.

The surgical cases were the usual type seen in the naval hospital. Battle casualties were at a minimum and almost all cases had been given previous definite therapy and had been evacuated to this activity for continuation of treatment and then for disposition. The battle casualties brought to this hospital were from one of the American torpedoed vessels; the major injuries suffered were fractured vertebrae.

During the period of this hospital's history the surgical service performed a total of 2,872 operations and the mortality rate of a total of 10 deaths seems exceptionally low for a two year period.[9]

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as follows:

1. "Electrocardiographic Changes Due to Carbon Tetrachloride Poisoning," by Lt. Comdr. H. B. Conway, (MC), USNR, and F. Hoven, PhM 2/c, USNR.
2. "Acute Infective Jaundice (Acute Hepatitis)," by Lt. Comdr. H. B. Conway, (MC), USNR, and Lt. Comdr. J. F. Shaul, (MC), USNR.
3. "Penicillin Therapy in Relapsing Fever," by Lt. Comdr. J. F. Shaul, (MC), USNR, and Lt. T. H. Safferstein, (MC), USNR.

9. Historical Data of U. S. Naval Base Hospital No. 9, Oran, Algeria, for 1945 in files of Administrative History Section, pp. 5-6.
   Resume of total cases of surgical service: Resume of deaths and causes thereof:

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The two rooms for major surgery and orthopedic surgery as well as the plaster room were well equipped.

The laboratory of the hospital was well supplied and very well equipped for a mobile unit. The greatest difficulty which had to be overcome was the lack of thoroughly trained personnel. The majority of the corpsmen received their training at the hospital.

The eye, ear, nose and throat service was housed in four Quonset huts. The equipment and supplies were considered most satisfactory for all clinical and surgical procedures. Base Optical Unit Number 7 began operating at the hospital on 4 November 1944. It was equipped to fill all routine eye prescriptions with the exception of high corrections. Excellent service was rendered by the unit at all times, but it did not have sufficient demand in any sense to use its maximum capacity of production at any time.

Facilities available for treatment in the neuropsychiatric

Total operations	2,782
Major operations	384
Minor operations	1,543
Instrumental Examinations	292
Casts applied	653
Orthopedic Manipulations	8
Plaster splints applied	44

(a) Post operative peritonitis....
(b) Burn...60% body surface
(c) Multiple injuries..ruptures of liver, diaphram and spleen
(d) Gunshot wound of abdomen.. died of severe hemorrhage from ruptured liver.
(e) Other six cases were skull fractures, and died without surgery.

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service were meager. There was no hydrotherapy other than cold packs. The use of insulin, metrazal or electric shock was not permitted thus handicapping full treatment for specific conditions. The sanitary reports stated that two strong rooms were hardly sufficient to care for the disturbed patients. Moreover, the lack of shock therapy increased the hospital stay of the disturbed patients. During the peak load months there was only one neuropsychiatric specialist.

The X-ray department functioned as an integral unit in a single Quonset hut where various examinations were performed with adequate equipment and facilities.

The dental department, organized and housed in two Quonset huts, was completely equipped with operating room, two complete general dentistry units, and a portable prosthetic laboratory unit. General dental treatment was administered to all personnel of the Navy, Marine Corps and Coast Guard on active duty. Prosthetic dental treatment was given to the afore-mentioned services in addition to the U. S. Army and service members of the United Nations in the area. The high standard of work performed was attested to in the following statement: "The quality of dental service rendered at Base Hospital Number 9 is by far above the average for an activity of this size whether within or without the continental limits of the United States."[10]

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10. Historical Data of the U. S. Naval Hospital No. 9 Oran, Algeria, for 1945 in files of Administrative History Section, p. 15. Case Statistics:

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Equipment and supplies were considered satisfactory and adequate for all clinical and surgical procedures in the urological service.

The health of the hospital was good throughout its history. There were no outbreaks of communicable diseases or dysentery among the patients or staff personnel, although mild bacillary dysentery epidemics occurred at nearby activities necessitating hospitalization of a number of cases at one time. The diligent work of the sanitation officer and his staff, the location of the hospital away from densely populated centers keeping contacts with communicable diseases of the port area at a minimum, the modern sewerage system, thorough screening of all buildings and the fact that water for the hospital was pumped from a deep well and was constantly chlorinated were the most important contributory factors toward the control of communicable diseases.

Epidemiology Unit Number 23 was assigned to the area in March 1944 and undertook many investigations. The investigation of the water supply resulted in thorough chlorination of all water used. A

Operative dentistry - total number of restorations.. 8,959;
prophylaxis..... 2,705;
Oral surgery - mandible and maxilla fractures..... 21;
extractions..... 2,490
Prosthodontia and Laboratory Procedures - dentures, full and partial.. 1,642

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survey of prostitutes in the area revealed that 85 percent of the women engaged in prostitution were carriers of gonococci. A plan whereby these women could be put under treatment for five days was quite successful but had to be dropped when evidence of resentment in the civilian population was revealed.

When several cases of bubonic plague occurred in Oran in January 1945, the epidemiologist of the Navy, by common consent, was made the control officer, responsible for all necessary control measures. Epidemiology Unit Number 23 was responsible for enforcing regulations, whereby the entire port area was sprayed with DDT and all contacts among the civilian population were isolated at the civilian hospital. Malaria cases admitted to the hospital had contracted the disease elsewhere. Typhus fever never reached epidemic proportions and when an epidemic of typhoid fever occurred in Oran in September and October 1944 no cases developed among naval personnel either at this hospital or elsewhere at the base. The general hospital admission rate for venereal disease was high, although it was extremely low for the hospital staff.[11]

The personnel of Base Hospital Number 9 at Oran varied slightly during the years of its history. The medical officers varied from 17 to 22; the dental officers generally numbered 3; the Hospital

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11. Annual Sanitary Report for the Year 1944 of U. S. Naval Base Hospital No. 9 Oran, Algeria, in files of Administrative History Section, p. 5.

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Corps officers, 4; pharmacists, 1; Chaplain Corps officers, 1; Hospital Corps ratings from 250 to 256 and miscellaneous ratings from 62 to 75. During 1944 there were 17 Navy Nurse Corps officers, and, in addition, that same year 3 Red Cross workers were assigned to the hospital for duty. The number of enlisted personnel on board was considered adequate, but it remained consistently below the authorized complement of 266 hospital corpsmen and 81 miscellaneous ratings.

The patients and staff of the hospital were comfortably housed in well heated, screened and ventilated Quonset hut units. All the facilities - galley, bake shop, scullery and laundry - were modernly equipped. The reports from the hospital indicated that the general hygienic considerations existent at this base hospital "closely approach the ideal for this type of a naval activity."[12] There were no outbreaks of food poisoning in the entire history of the hospital.

This hospital had well equipped facilities for athletics and recreation - a good ball diamond, basketball court, two tennis courts, badminton courts, horseshoe-pitching layouts, boxing and wrestling ring and ping-pong tables. Daily movies were available on the hospital compound. Two Red Cross huts were equipped for games, a

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12. Annual Sanitary Report of the U. S. Naval Base Hospital No. 9, Oran, Algeria, for Calendar Year 1943 in files of Administrative History Section, p. 7.

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library and music. Ship's company dances were held at intervals. Trips were made to points of interest in the area. In the city of Oran the Red Cross maintained the huge Empire Club, and in season it kept a beach club open for servicemen. The variety of the recreation and occupational therapy programs was very popular with the patients and staff. The hospital commended the Red Cross workers for their fine contribution in promoting the morale and welfare of the patients and staff of this hospital.[13]

United States Naval Base Hospital Number 9 at Oran remained a separate command as part of Commander U. S. Naval Forces, Northwest African Waters. It was an integral unit of U. S. Naval Operating Base, Oran, Algeria, from its inception to 30 September 1945 when it was decommissioned. The accompanying chart, Enclosure C , succinctly explains the organization of the hospital. Graph A shows the command relationship of this hospital to the Staff Medical Officer of the

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13. Historical Data of U. S. Naval Base Hospital No. 9, Oran, Algeria, for 1945, in files of Administrative History Section.
In addition to routine and aid service the activities developed by the Red Cross workers included many types of handicraft such as weaving, leather and metal work of all types; horse-racing, bingo and card parties; screening of Oran girls for beach parties and dances; special arrangements for holiday parties; birthday celebrations for bed patients; French classes, symphony programs, lecture programs, moving picture shows, etc.

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Naval Operating Base who was responsible to the authority of the Force Medical Officer of the Command, Naval Forces Northwest African Waters. Enclosure D shows the command relationship of the hospital to the U. S. Naval Detachment, Oran. These charts present a clearer representation of the administrative picture than a verbal description could give. This hospital was one of the principal medical facilities under the control and administrative authority of the U. S. Eighth Fleet operating in the Mediterranean area.

The U. S. Naval Dispensary, U. S. Naval Station, Oran, Algeria, was an important connecting link in the chain of medical facilities in the Northwest African theatre. This dispensary functioned as the only dispensary (other than the port dispensary available in this area to military and Merchant Marine personnel) except for an army dispensary at La Senia Airport, about six miles from Oran. Examinations were carried on and first-aid treatment rendered for civilian employees of the Army and Navy who had been injured while at work. The senior medical officer of this dispensary was also in command of the port dispensary. Many of the patients from the latter installation were brought to the U. S. Naval Dispensary, Oran, or to the U. S. Naval Base Hospital Number 9 for consultation and treatment.

The over-all purpose and function of this particular unit did not change much through the war years. This naval dispensary was directly under the commanding officer of the naval station. All health records of personnel attached to the U. S. Naval Station and the Naval

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Operating Base were kept at this dispensary. The patients who reported there were either treated ambulatorily or, if the circumstances warranted, were transferred to U. S. Naval Base Hospital Number 9, Oran. It was the function of the port surgeon, attached to the dispensary, to supervise the port dispensary and to make sanitary inspections in the port. This dispensary acted as liaison between ships afloat and U. S. Naval Base Hospital Number 9. Actually, this meant furnishing the major portion of transportation of personnel and gear to the hospital. The dispensary also served as a place of sick call for ships which carried no medical officers. The X-ray department and the laboratory were especially important in serving personnel of ships afloat, both for those ships having medical officers and those having no medical officer. The evacuation of the wounded has been largely accomplished through the port dispensary with the aid of ambulances from this U. S. Naval Station Dispensary.

Although endemic in the region, bacillary dysentery never appeared in epidemic form at any one time. Strict control of personnel and stringent measures, particularly proper elimination of the insect menace, apparently controlled bacillary dysentery at this station.

On 18 January 1945 seven cases of plague were reported among the French civilians in Oran, but no cases were reported among naval or military personnel. The spread of the disease was successfully controlled, as previously indicated in the discussion of the U. S. Naval Base Hospital Number 9, through stringent prophylaxis, intensive

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efforts to exterminate rats and the restriction of personnel to areas known to be free of plague.

In a region where heat, flies, dirt and water supply create difficult problems, this unit attained a high standard of naval hygiene in living conditions. The venereal disease program instituted at this dispensary at Oran was effective in maintaining a low venereal rate among station personnel in a vicinity where there is a high civilian incidence of venereal disease.

The U. S. Naval Port Dispensary at Oran, Algeria, was also available to military and Merchant Marine personnel in the area. It was under the command of the Commander, U. S. Naval Station, Oran, Algeria, and it was under the direction of the senior medical officer of the U. S. Naval Dispensary, Oran. This dispensary was responsible for inoculations in the port area, the inspection of ships in the Oran port, and the port of Mers-el-Kebir, Algeria. It was also responsible for the embarkation and debarkation of casualties who were U. S. military and naval personnel and military personnel of Allied nations, particularly French, and some prisoners of war, German and Italian. One medical officer attached to the U. S. Naval Station, Oran, acted as the medical officer for the port dispensary and as port surgeon. He supervised the port dispensary and made sanitary inspections in the port. This medical unit was decommissioned 15 July 1945.

The U. S. Naval Station, Mers-el-Kebir, had a dispensary constituting a staff of 12 officers and 160 enlisted men. An assigned

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sanitation officer, who was one of the dispensary medical officers of U. S. Naval Dispensary, U. S. Naval Station, Oran, Algeria, made sanitary inspections of this installation in addition to his sick call duty twice a week at the station.

The Advance Base Groups destined for Sicily arrived in the theatre in May 1943. These Advance Base Groups, collectively designated "SPAN," originated 25 March 1943 at the Receiving Station, NOB, Norfolk, Virginia.[14] They were composed of four dispensary units. All units that comprised 'SPAN' sailed from Norfolk, Virginia, 10 May 1943, on board the USS LYON, OBERON and FREDERICK LYKES; two weeks later the convoy arrived in Oran, Algeria.

Quarters were established for SPAN organization in Gambetta section of Oran, Africa, in a tent camp which had formerly been occupied by U. S. Army personnel. Shortly after, a 25-bed dispensary was set up in a large tent in which a wooden deck had been installed.

The history of the four separate units becomes a story of the gradual amalgamation of all into one compact organization. Unit I sent

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14. Historical Supplement to Fourth Quarterly Sanitary Report for Period of World War II of U. S. Naval Dispensary, NOB, Palermo, Sicily, in files of Administrative History Section. Four dispensary units divided as follows:

Unit I (DIZO)	200-bed dispensary cut to 50-bed capacity
Unit II (GAVU)	50-bed dispensary cut to 25-bed capacity
Unit III (HURA)	50-bed dispensary cut to 25-bed capacity
Unit IV (ZACA)	50-bed dispensary cut to 25-bed capacity

These had been reduced after a preliminary period of organization.

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out an advance group which departed with an overland convoy and arrived in Bizerte, 20 July 1943, then headed for Palermo, arriving there three days later. In the meantime, Unit II had left Oran for Italy, landing at Gela, Sicily, where a small dispensary and sick bay was set up 11 July 1943. This unit merged with Unit IV at Lixata, Sicily, 18 August 1943. Unit III departed for Bizerte, joining Unit IV at this point and after a temporary location at Bizerte, departed for Locata, Sicily, where the units disbanded 28 August 1943 and both joined Unit I in Palermo, Sicily. Meanwhile, Unit II had merged with Unit IV, had undergone dispersement with Units III and IV, and had joined Unit I in Palermo. Hence, the original plan, whereby the 50-bed unit had been destined to go to lesser ports on the south coast of the island, had been abandoned entirely. The satellite units were never set up completely, because all U. S. Navy activities had been consolidated at Palermo as the Naval Operating Base. With the personnel and equipment which had been brought together through consolidation, a dispensary of 160 beds was established.

The medical department, NOB, Palermo, Sicily, had been established 1 August 1943. However, since all four units had been combined to form a composite organization by 28 August 1943, the relative measure of the department permitted it to be designated as a dispensary. The initial flexible organization of the units had permitted changes in the set up, and just as varying conditions had brought about amalgamation of the units, so this dispensary, through the ingenious methods it used in caring for casualties and the resourcefulness it

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developed in securing supplies and equipment, although never designated as such, actually functioned as a hospital. It provided hospitalization for all U. S. Navy personnel stationed in Sicily. As established, this hospital-functioning dispensary included the following: surgical and medical service, urology and venereal disease control, laboratory and sanitation, X-ray and dental departments.[15]

At first this unit functioned in conjunction with the local Army hospital, but an adequate organization had been established by 6 July 1944 when the Army hospital in the area was given up. After that time, all commitments in the area for Army, Navy, Merchant Marine and United Nations personnel for medical dental treatment were assumed by this activity.

Sudden increases in patient load in the dispensary followed as a consequence of the Salerno and subsequent Anzio invasions when the casualties of enemy action were brought into the dispensary. At various times patients surviving individual ship actions were given emergency treatment. Twenty-two wounded were evacuated from the USS BUCK in October 1943; most of the survivors admitted suffered from immersion blast injuries.

The enteric fever outbreak in August, September and October of 1944 was the most important incident in the epidemiological history

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15. Historical Supplement to Fourth Quarterly Sanitary Report for World War II, US Naval Dispensary, NOB, Palermo, Sicily, in files of Administrative History Section, p. 6.

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of the dispensary. Typhoid and paratyphoid are endemic in Palermo with high seasonal incidence. From August through October a total of 33 patients were admitted to the dispensary with a diagnosis of paratyphoid A or B fever in addition to five typhoid cases.[16] This enteric fever outbreak was investigated by Epidemiology Unit Number 23 which indicated that the outbreak could not be attributed to any one single cause.[17]

Dysentery abruptly declined in frequency as soon as drinking had been limited to chlorinated water and all heads and galleys had been screened. Although the area was comparatively free of malaria, a malaria control unit was established under U. S. Army supervision.

Possibly because of the color disparity, venereal disease control was not a problem in Africa but a decidedly upward trend in the venereal disease rate was noted in Sicily shortly after the work in establishing the base had been completed. Additional prophylaxis stations were established and recreational facilities were improved, but despite intensive educational programs and control measures this

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16. Historical Supplement to Fourth Quarterly Sanitary Report for World War II, US Naval Dispensary, NOB, Palermo, Sicily, in files of Administrative History Section; the 33 patients included 30 naval personnel, 2 Army and 1 Italian POW.

17. Historical Supplement to Fourth Quarterly Sanitary Report for World War II, USNaval Dispensary, NOB, Palermo, Sicily.
The inv stigation reported stated: "No single cause can be proven as the most important one in the outbreak. The seasonal distribution emphasizes the unimportance of flies as factors in this outbreak, but it also points toward the importance of the factor of contaminated water in the spread. During the warm months the dispensary laboratory found a much higher percentage of positive water samples than was found by us recently."

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was the least effective phase of the local medical program.

Originally a composite of four medical units, this installation functioned as a naval dispensary, but as its functions expanded and hospitalization was extended to all Army, Merchant Marine and United Nations personnel in addition to U. S. Navy patients, it assumed the proportions of a small hospital. Locally but never officially it was given the designation. It was a component of the U. S. Eighth Fleet, Commander Naval Forces North African Waters. In relation to chain of command it was under the immediate administrative authority of the Commandant, Naval Operating Base, Palermo, Sicily, who operated under the command of the U. S. Eighth Fleet, which was directly under Cominch. Also, there was a smaller dispensary distinguished as port dispensary in the Palermo port area, similarly under the administration of Commandant, NOB, Palermo.

During the summer of 1943 it was necessary to provide dispensary facilities for the Salvage Unit at Dellys, Algeria, during the summer of 1943 and for the naval detachment, Naples, in October 1943. The Dellys unit obtained necessary equipment from the United States while equipment, material and personnel already in the theatre were used for Naples. Dispensary facilities were also set up at the AATB, Salerno, in May 1940, with the equipment and personnel from Arzew. A 10-bed dispensary unit was established at Ajaccio, Corsica, early in 1944 with personnel obtained from the United States. Three 25-bed

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dispensary units were founded for the Motor Torpedo Boat Squadron bases at Calvi and Bastia, Corsica and Maddalene Island, Sardinia, early in 1944.

Medical Storehouse Number 9, which was the source of most bulk medical supplies and equipment for these activities in the Northwest African theatre, was moved out of Casablanca to Oran early in 1944 because of the reduced shipping in the former port. Its location in Oran expedited the distribution of naval medical supplies to the more active bases in and near the operation zones.

One of the last of the medical installations to be set up in this area was the U. S. Naval Dispensary, Rome, commissioned 1 January 1945. This dispensary was established by the commander of the Eighth Fleet to offer medical facilities to the personnel of our naval groups located in Rome. In addition, the U. S. Ambassador to Italy, his staff and the State Department, the American Army, and British service personnel with no other naval medical facilities available received care.

This department was not faced with any outstanding medical or surgical cases, no battle casualties and no epidemics. In holding the position of a rear echelon this dispensary carried on medical work of an almost routine nature.[18] The most common dis-

18. Historical Supplement to Fourth Quarterly Sanitary Report of U. S. Naval Dispensary, Rome, Cumulative Report for Period of World War II, in files of Administrative History Section. This medical department concerned itself with (1) Medical and minor

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order encountered was acute diarrhea, a condition which seemed to be almost universal among foreigners to Rome and occurred sporadically. The origin and cause of the disease could not be determined. The climate of Rome seemed to be conducive to upper respiratory infections in foreigners. Peculiarly enough, relief was obtained for persons having acute attacks of sinusitis by having the patient sleep in a warm, poorly ventilated room. Aside from the frequency of these conditions mentioned, the level of general health at this activity was high.

The dispensary, Naval Detachment, Marseille, was a composite of two G-8 medical units, organized for advanced base groups originally designated as Navy 3605 and Navy 3110. It was a component of the U. S. Eighth Fleet, Commander Naval Forces Northwest African Waters and U. S. Naval Advanced Base Southern France.

Naval advanced base groups were assigned to take Marseille in conjunction with U. S. Army and British and French navies. The operation was extremely flexible. By the middle of October the French Navy took over the port of Toulon and two weeks later the U. S. Naval Detachment, Toulon, moved out and merged with the U. S. Naval Detachment of Marseille. The two medical dispensaries

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surgical care of the patients described; (2) Maintenance of sanitation in all its aspects including venereal disease control; (3) Performance of indicated physical examinations; (4) Prophylaxis against epidemic and contagious diseases; (5) Establishment of liaison with 73rd (now 34th) U. S. Army Station Hospital.

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merged with all personnel, equipment and supplies. These two medical units operated as naval dispensaries in conjunction with U. S. Army hospitals.

Shortly afterwards, these two units merged into one as the Naval Dispensary, Marseille. Patients who were critically ill or injured were handled by the U. S. Army hospital facilities in this area. In the first weeks after the invasion of Southern France, this dispensary unit treated a number of blast casualties caused mainly by land mines. First aid was administered quickly and the casualties were evacuated either to U. S. Army hospitals or the French Naval Hospital in Toulon.

No serious epidemics occurred in Southern France. There was a mild initial outbreak of dysentery which was not infectious. The venereal rate of the city was extremely high. U. S. naval personnel cases responded 100 percent both clinically and serologically to penicillin.[19]

The primary purpose of the Naval Dispensary, Marseille, in addition to treatment of sick and wounded, sanitation, and preventive medicine, was to correlate, evaluate, record, classify and direct all medical activities concerning naval personnel both stationary and transit in this area. The unit was decommissioned

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19. Supplement to Fourth Quarterly Sanitary Report, Historical Data, Dec. 1945, of U. S. Naval Detachment Dispensary, Marseille, France, in files of Administrative History Section, p. 6.

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15 October 1945.

Medical supervision with the United States and British Army medical units was mutually coordinated throughout the period of Allied activities in the Mediterranean area. The policy of hospitalizing U. S. Army hospitals was started in 1943 and continued until April 1944. In fact, the coodination of U. S. Navy Medical Corps with that of the Allied services was promoted and carried out very successfully throughout the war period in this area. In the supply realm, the U. S. Army provided many medical supplies at places which were far removed from the naval medical storehouse on agreements of a universal logistic supply basis. The difference between medical supplies used by the Army and Navy is not great.

The attached chart indicates the medical installations that were active in the Mediterranean Area as of 1 January 1945 under the command of the United States Eighth Fleet. Attention has been fixed on the more important of these installations in the foregoing detailed consideration. The medical installations in the Northwest African theatre were specifically under the administrative command of Commander Task Force 125 of the United States Eighth Fleet which operated directly under the administrative supervision of Cominch. This is graphically represented in the accompanying chart showing the organization of this task force which is much clearer than any literal interpretation.

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MEDICAL DEPARTMENT FACILITIES IN OPERATION IN THE UNITED STATES EIGHTH FLEET AS OF 1 JANUARY 1945

ACTIVITY	BED CAPACITY	OFFICERS: MEDICAL CORPS	OFFICERS: DENTAL CORPS	OFFICERS: HOSPITAL CORPS	OFFICERS: NURSE CORPS	ENLISTED: HOSPITAL CORPS
ALGERIA-AFRICA						
ALGIERS - Port Sick Bay (SUSNO-Algiers)	4	0	0	0	0	2
ARZEW - Dispensary, U. S. Naval Station	98	2	1	1	0	24
Dispensary, Salvage Forces (Base)	8	1	0	0	0	4
ORAN - Base Hospital No. 9	500	19	3	5	17	255
Dispensary, U. S. Naval	44	3	1	2	0	57
Dispensary, Receiving Station.	0	1	0	0	0	17
Dispensary, Naval Supply Depot.	0	1	1	0	0	18
Medical Storehouse No. 9.	0	0	0	2	0	20
*Port Dispensary	0	2	0	0	0	14
*Personnel attached to U. S. Naval Station.						
MERS-EL-KEBIR - Sick Bay, Naval Station	6	0	0	0	0	3
FRANCE						
MARSEILLES - U. S. Naval Detachment.	10	1	1	0	0	6
GOLFE JUAN - *PT Base	0	0	0	0	0	4
*Personnel attached to PT BASE #12.						
FRENCH MOROCCO - AFRICA						
AGADIR - *Sick Bay, FAW-15 (Detachment No. 1)	68	1	0	0	0	4
*Personnel attached to FAW-15.						

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CASABLANCA - *Base Hospital No. 5.	96	6	2	3	0	63
Barracks Dispensary, NOB	0	0	0	0	0	8

*Capable of immediate expansion to 200 beds.

PORT LYAUTEY -(Dispensary) Sick Bay(NAS))	130	*9	3	3	0	**68

* Two medical officers and 1 dental officer are attached to FAW-15.

** 46 Hospital Corps personnel (enlisted) attached to NAS and 22 to FAW-15.

TUNISIA-AFRICA

BIZERTE - Dispensary, AATB	68	5	2	1	3	41

SICILY

PALERMO - Dispensary, NOB Sick Bay (Port Area)	155	8	3	2	4	77

ITALY

NAPLES - Dispensary, U. S. Naval Detachment	140	5	1	1	4	32
LEGHORN - PT Base (MTBRON #22)	0	1	1	0	0	9
ROME - Dispensary (SENALUSLO)	4	1	0	0	0	3

SARDINIA

MADDALENE ISLAND - PT Base #12	10	1	1	0	0	10

TOTAL BED CAPACITY 1341

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Section 3 United Kingdom Medical Installations

Commander, Landing Craft and Bases, Europe, was commissioned 1 September 1943 in Washington, D. C. This command established headquarters in Falmouth, England, 30 October 1943 and from thence it moved to Plymouth, England, January 1944. The title of the command was changed to Commander, Amphibious Bases, United Kingdom, and a collateral title of Commander, Task Force 123, was added 24 September 1944. The components of the command were basically the same throughout the war period, namely, all amphibious bases, U. S. Naval Base Number 2 and, from time to time, all U. S. naval amphibious ships and craft operating in and about the United Kingdom.

The total personnel, ashore and afloat, served by this task force fluctuated greatly, reaching a high point in June 1944 of approximately 22,000 ashore and 87,000 afloat.[20] The amphibious operating bases and sub-bases of this command were located on the southern and southwestern coasts of England in the area reaching from Deptford on the Thames to Milford Haven on Bristol Channel with the exception of U. S. Naval Base Number 2, Roseneath, Scotland. The principal ones were situated on the English Channel between Portsmouth and Falmouth. They had been established in preparation

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20. Annual Sanitary Report of Commander Amphibious Bases, United Kingdom, for year ending 3 Dec. 1944 in files of Administrative History Section, p. 2. Total number of personnel ashore and afloat served by this task force numbered 14,363 ashore and 5,400 afloat in Jan. 1944; 22,000 ashore and 87,000 afloat in June 1944; declined slightly during July and Aug. and on 31 Dec. 1944 there were 17,800 ashore and 17,400 afloat.

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for the Normandy invasion.

Shore-based medical facilities, once established, functioned very well, according to the sanitary reports submitted by those facilities and the Twelfth Fleet sanitary report. Prior to the invasion of Normandy, all shore-based medical activities of the command increased their capacities, primarily by the addition of beds, in anticipation of casualties.

The accompanying chart indicates the shore-based medical activities under this command. The various dispensaries which were established at or in the vicinity of naval amphibious bases and, for the most part, the bed capacities were proportional to the number of personnel in the various commands. The installations whose bed capacities were augmented to handle unexpected casualty numbers included those at Plymouth, Portland-Weymouth, Dartmouth and Milford Haven. The dispensaries at St. Mawes (22 beds), Appledore (61 beds) and Teignmouth (50 beds),which had been set at temporary bases, were closed prior to D-day. The equipment of these facilities was sent to other places.

Base Number 1 at Londonderry, Northern Ireland, contained the naval base hospital, a medical supply storehouse and a medical department at the U. S. N. Radio Station at Londonderry, Northern Ireland. The base itself consisted of four camps and a Navy yard, all within a radius of about five miles, on sloping ground which was easily drained. The main dispensary, or U. S. Naval Base Hospital Number 1 at Londonderry, was commissioned in February 1942.

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Shore-Based Medical Activities (Dispensaries) Established Under Commander, Amphibious Bases, United Kingdom

Title and Location	Number of Beds	Maximum Capacity	Commissioned	Decommissioned
U. S. N. Base Number 2 Roseneath, Scotland	175	325	8-24-42 (didn't come under this command until Oct. 1943)	———
USNAATB Appledore, Devon	25	61	7-29-43	5-25-44
USNAATSB St. Mawes, Cornwall	34	34	9-7-43	5-20-44
USNAAB Falmouth, Cornwall	100	220	10-11-43	———
USNAATSB Fowey, Cornwall	50	93	10-25-43	8-1-44
USNAAB Plymouth, Devon	327	500	11-6-43	———
USNAATSB Salcombe, Devon	50	117	11-25-43	8-7-44 (reopened on 12-19-44 with .25 beds)
USNAATSB Tiegnmouth, Devon	50	87	12-1-43 (never commissioned)	4-28-44 (but in full operation between dates shown)
USNAAB Dartmouth, Devon	300	356	12-24-43	———
USNAAB Milford Haven, Wales	200	800	1-12-44	10-16-44

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USNAAMSB Penarth, Wales	50	50	1-12-44	7-16-44
USNASB Exeter, Devon	25	46	2-3-44	_____
USNAAMB Deptford, London	10	10	4-10-44	8-31-44
USNAAB Portland-Weymouth, Dorset	50	123	5-1-44	_____
USNAAB Poole, Dorset	20	24	5-11-44	8-6-44
USNAAB Southampton, Hants	10	10	5-11-44	_____

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This hospital of 300 beds was capable of an additional 100-bed expansion. Sub-dispensaries were maintained in all the camps comprising the base and a first-aid station was set up in the Navy yard. All the buildings, including the living quarters, were of the Quonset hut variety. A great many of the Allied services were cared for at this hospital.[21] An out-patient and consultation service was maintained for the Allied forces.

There were no epidemics in the history of the hospital and only one outbreak of food poisoning during 1943. The water supply came from the city reservoirs. The facilities for the treatment of the sick were considered ample and were not taxed to capacity. The annual allowance for medical, surgical and dental supplies was sufficient. Hospital supplies were secured from Naval Medical Supply Storehouse Number 5, which was under the same command and

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21. Annual Sanitary Report of the U. S. Naval Operating Base at Londonderry, Northern Ireland, for year 1943, in files of Administrative History Section, p. 5.
During 1943 this hospital cared for members of the following branches of the Allied services who had the following sick days:

Royal Navy (British)	19,627
Royal Air Force (British)	1,512
Royal Marines (British)	106
British Army	427
Royal Canadian Navy	2,625
Royal Canadian Air Force	315
Royal Australian Air Force	5
Royal New Zealand Navy	22
Royal Indian Navy	35
Royal Netherlands Navy	42
Royal Norwegian Navy	184
Royal Polish Navy	100
Royal Greek Navy	22
Greek Merchant Marine	7

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occupied buildings at the hospital. This was the only source of naval medical supply in this theater until Medical Supply Storehouse Number 12 was established at Exeter.

Base Hospital Number 1 was under the administrative direction of the Commander, U. S. Naval Forces in Europe, acting under ComNavEu, collaterally under the supervision of the Bureau of Medicine and Surgery, Washington, D. C. It was decommissioned 25 August 1944.

The medical department at U. S. N. Radio Station, Londonderry, commissioned 10 July 1944, maintained battle-dressing stations at Clooney Radio Receiving Station and Ross Downey Transmitting Station during the war. The main dressing station, located at Clooney Park Camp, consisted of a 10-bed dispensary. The station was never attacked by enemy aircraft or enemy personnel. There was only one death in the history of the station - attributed to acute poisoning from methyl alcohol. There was no problem of supply. Surgical procedures at this station were referred to the 55th Field Hospital, U. S. Army, located at Langford Lodge, Londonderry.

In the planning period for the Normandy invasion arrangements were made to establish a base hospital in the premises of the Royal Victoria Military Hospital at Netley Hants on Southampton Water. Two buildings of the "Royal Military Hospital" were turned over to the U. S. Navy and 1 March 1944 it was commissioned as U. S. Naval

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Base Hospital Number 12. This hospital had a bed capacity of 1,088 and was capable of expansion to 1,500 by the use of certain barracks buildings.

With the assistance of the 97th Construction Battalion, the hospital was completely organized and equipped and the personnel were specially trained by 15 May 1944 to receive casualties to the limit of the hospital's bed capacity. This hospital, established primarily for the treatment of war casualties during the invasion, admitted only American sick and wounded after D-day, except in emergency cases. However, 1,358 patients for British services had received treatment prior to D-day. It was the only naval base hospital in England. Various naval activities in England transferred cases to it for treatment and the sick and injured naval personnel evacuated from U. S. Army and British hospitals were also received by the hospital.

During the seven months of the hospital's existence under naval command a total of 9,630 patients were admitted, of which 4,226 were war casualties.[22] There were 18 deaths during this period - 11 were the result of wounds incurred in action against the enemy. The mortality rate among all combat casualties received at the hospital was .26 of 1 percent. The first D-day casualties were received

22. Neuropsychiatric cases are not included among the war casualties.

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at the hospital on 9 June 1944, and in the following 3 months and 26 days a total of 7,877 patients (including 4,226 war casualties) were admitted.[23]

Generally, casualtics arrived in large groups-by ambulance from hospital carriers and LST's. Between 200 and 300 combat casualties were admitted in the course of a few hours on several occasions. Daily admissions of from 100 to 200 were not uncommon. All hands were needed to take care of such large-scale admissions.

All U. S. Navy patients requiring return to the United States from this area for further treatment or disposition were evacuated through this hospital. Prior to its establishment these patients had been evacuated through U. S. Naval Base Number 2 at Roseneath, Scotland. Evacuations through the base hospital proved a much more satisfactory arrangement because of its proximity to the southern bases where there were fewer travel difficulties. After

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23. Annual Sanitary Report of Commander, Twelfth Fleet, for year ending Dec. 1944, in files of administrative History Section, p. 10. Significant statistics to note in reference to admissions subsequent to 1 June: On 5 June (day before D-day) there were 481 patients in the hospital, consisting mostly of "briefed" patients and 188 U. S. Navy Coast Guard patients. On D-day all briefed patients (212) evacuated by hospital train and 56 non-briefed British patients were returned to duty. Subsequent monthly admissions were as follows:

June - 2,107	-	Included 1239 battle casualties (U. S. Navy-216; U. S. Army-1,009; others - 14)
July - 1,740	-	Included 1038 battle casualties (U. S. Navy-77; U. S. Army-954; others - 7)

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Base Hospital Number 12 had been decommissioned, U. S. Naval Advanced Amphibious Base, Plymouth, Devon, and U. S. Naval Base Number 2 were designated as evacuation centers for the southern and northern areas respectively. This arrangement of having two facilities, a northern and southern collecting center, to evacuate patients to the United States worked most satisfactorily. The U. S. Naval Base Hospital Number 12 was decommissioned on 30 September 1944.

One of the base dispensaries in the United Kingdom was U. S. Naval Base Number 2, comprising 550 acres located on the eastern and southern part of Roseneath peninsula. With lakes on the east and west, the Clyde River on the south, and high hills beyond the lakes, this dispensary had the advantages of a scenic situation. There were 10 permanent buildings in use at the base. In addition, there were 489 temporary buildings used as living quarters in the various areas, the majority of which were the standard Quonset type.[24]

August - 1,257 - Included 495 battle casualties (U. S. Navy-67; U. S. Army-427; others - 1)

September - 2,972 - Included 1,470 battle casualties (U. S. Navy-10; U. S. Army-1, 427; others - 33)

NOTE: See Appendix A for more complete information on monthly admissions.

24. Annual Sanitary Report of the U. S. Naval Base Number 2, Roseneath, Scotland, for the year 1944, p. 6. Usually 16 men were housed in one of these standard Quonset huts which is 16 feet by 9 feet, allowing 239.06 cubic feet of air space per man.

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No communicable disease occurred in any proportion approaching epidemic form, despite the fact that the rate of communicable disease in the city of Glasgow and nearby towns was high. Venereal diseases gave the medical personnel the greatest concern. Every available means of keeping the venereal disease rate as low as possible was used. The number of sick days caused by venereal diseases comprised more than one-third of all the sick days for all diseases. The rate per thousand for 1944 was almost twice that of 1943.[25]

The high rate of venereal disease on this base was attributed in great measure to the failure of local authorities to pick up and treat the contacts. The great increase in 1944 over 1943 was ascribed to the fact that most of the base personnel during 1944 were either returning from or going into combat areas.

The complement of 92 hospital corpsmen was insufficient for the size and widely spread units of that base. With the exception of one short period, the complement gaps were filled with transient Hospital Corps personnel, but the reports of this installation indi-

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25. Annual Sanitary Report of the U. S. Naval Base Number 2, Roseneath, Scotland, for the year 1944. The annual venereal disease rate on the base was 108.8 per thousand for 1944. For gonorrhea the rate per thousand for 1943 was 42.6, while in 1944 it was 93.19. The rate per thousand for syphilis was 13.04 and 14.08 respectively for those two years. This rate is based on the average strength of men stationed at U. S. N. Base Number 2 and does not include cases from the Armed Guard and other personnel from ships.

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cated that transients were never as dependable or efficient as permanent Hospital Corps personnel. An intensive training program was continued throughout 1944 for hospital corpsmen at the stations. Classes were held five days a week and attendance was compulsory for all men from HA 2/c to PhM 3/c inclusive.

The supply of water to the dispensary was inadequate at times because when water became lower than the 16 foot level in the storage tank it reached the level at which the pipe line passed over the hill on its way to the dispensary and thus gravity flow was interrupted. A ten day drought during 1944 caused an acute water shortage.

The allowance of medical, surgical and dental supplies was adequate for most needs of the dispensary but some difficulty was met in obtaining a few particular drugs. Sulfathiazole and sulfadiazine used for the treatment of gonorrhea did not bring very satisfactory results - failures ran as high as 50 percent during some months. In late 1944 when supplies of penicillin became available immediately, results of better than 95 percent cures were achieved.

The dispensary, U. S. Naval Base Number 2, Roseneath, Scotland, was organized under the administrative authority of the Commander Amphibious Bases, United Kingdom, which looked to the higher echelon of the Commander, U. S. Naval Forces in Europe,

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ComNavEu, Cominch and collaterally to the Bureau of Medicine and Surgery of the Navy Department in Washington.

The U. S. Naval Dispensary, London, England, was established in a fashionable part of the city, 18 Grosvenor Square, as part of the command of the United States Special Naval Observer. When Adm. H. R. Stark, USN, Commander, U. S. Naval Forces in Europe, established his headquarters in London on 23 March 1942, this dispensary became part of that command with the commanding officer assuming a dual role as senior medical officer of the dispensary and head of the medical section of U. S. Naval Forces in Europe.

With the marked increase in naval personnel in the London area, the dispensary was moved to its present location, 50 Upper Brook Street, on 15 February 1944. This building with its 29 rooms permitted the installation of 35 beds and provided space for the establishment of the specialities, eye-ear-nose-throat, surgery, urology, internal medicine and dentistry.

A branch dispensary of 50 beds was established in two Blackheath sections of London on 15 June 1944 to care for convalescent and overflow patients from the main dispensary and to serve as a dressing station for bomb casualties. A month later it was closed on grounds that there was actually no need for the branch dispensary.

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The London dispensary was quite busy from January 1944 to July 1945. In addition to the large number of naval personnel needing care, many American Embassy personnel, members of commissions from Washington, a few members of the British Army and Navy, and Dutch, Russian and Chinese navies were treated as out-patients. No casualties were received from the continent and its few war injury cases consisted of bomb casualties and casualties from armed guard crews of torpedoed or mined ships. The dispensary was responsible for the sick and injured of all armed guard personnel admitted to any British or U. S. Army hospital in the United Kingdom. Its work steadily declined after June 1945 with a definite curtailment of staff personnel.

There were no epidemic diseases at this command; but despite an intensive educational campaign for prevention of venereal disease and the availability of many prophylactic stations scattered throughout London, the venereal rate remained high.[26]

This dispensary was a part of the medical section of the U. S. Naval Forces in Europe. It was designated as Headquarters Dispensary and for administrative purposes it was under the cognizance of the Commanding Officer, Headquarters Company, ComNavEu. The head of the medical section was the staff medical officer of the U. S. Naval Forces in Europe. The senior medical officer on duty in the dispensary was designated as Medical Officer in Charge. The various medical and

26. Historical Supplement to Fourth Quarterly Sanitary Report 1945, for Headquarters Dispensary, U. S. Naval Forces in Europe, (London,

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dental officers representing the medical, dental and surgical specialties were directly under the medical officer in charge.

The United States Naval Amphibious Supply Base, Exeter, Devon, England, was commissioned 3 February 1944 as a 10-bed dispensary in Quonset huts. As necessity arose, it increased to a maximum of 54 beds with fully equipped medical facilities. This was typical of the smaller naval establishments in the United Kingdom.

The United States Naval Amphibious Supply Base, Exeter, Devon, or Storehouse Number 12, was the central supply base for the U. S. Navy in European waters. It was under the administrative direction of ComNavEu, London, operating through Commander, Amphibious Forces, United Kingdom, Plymouth, Devon, England. The story of the operations of this naval medical storehouse from 15 April 1944 to September 1944 is the logistic report of the medical supply load for the Normandy invasion. After September 1944 it supplied medical items to all U. S. naval activities in the European theater of operations as well as received medical supplies and equipment from decommissioned units in that theatre.

During the five month period prior to D-day, the eventual number of available beds in England for reception of casualties reached a total of 3,500. This had been accomplished through completing additional medical facilities including Base Hospital Number

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England), in files of Administrative History Section, p. 4. The average venereal rate for the period Jan. - Aug. 1945 was 77.2 per 1000 per year.

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12 at Netley and through providing additional beds at dispensaries already established. Plans were made for the evacuation of casualties during and after the initial assault. It was decided to use specially equipped LST's for the purpose. A survey of the resupply points was made and certain ones were designated for the reception of casualties. Most of the casualties carried by the LST's were disembarked at Southampton and Portland-Weymouth where patients were sorted - British patients into the British evacuation chain and American into the American chain.

According to the logistic plan for the Normandy invasion, operation OVERLORD, it had been determined that the care of casualties occurring as the result of enemy contact during the invasion was an Army commitment. But, U. S. naval medical activities were to care for casualties resulting from loading accidents or near-shore attacks by the enemy. These installations were required to receive and transfer from the Army any naval casualties returned from the far shore and to receive any casualties who were in poor condition on arrival at near-shore unloading points. It was further determined that the return of casualties from the far shore would be a Navy commitment and the LST's would be used for this purpose. One hundred and six LST's were alloted for casualty handling.[27] Alterations were made in the

27. Annual Sanitary Report of Commander, Twelfth Fleet, for year ending 31 Dec. 1944--Comdr. L. G. Bell, who played an important part in the operation, reported that the medical personnel for these 106 LST's were distributed as follows:

90 LST's.....3 medical officers.....20 hospital corpsmen
13 LST's.....2 medical officers.....20 hospital corpsmen
3 LST's.....1 medical officer.....20 hospital corpsmen

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vessels to make them more suitable for casualty handling.

A training course for orientation and indoctrination in casualty handling for the inexperienced officers and men who came from the United States to perform this task was started in a school established 24 March 1944 at Fowey. In addition to basic amphibious indoctrination, an intensive course of 16 hours of chemical warfare lectures was given and, in conjunction with this training, a practical demonstration in casualty handling was held at Fowey.

Considerable detailed planning was necessary to give adequate medical logistic support to LST's for the operation. Each of the 106 LST's for the operation was equipped with necessary medical supplies and equipment to provide surgical and nursing care for an average lift of 200 casualties on each return voyage. Medical supply dumps had been established at Southampton, Portland-Weymouth and Brixham for replenishing medical materials. The excellent manner in which casualties were handled aboard LST's was born out in the testimony of Force Medical Officer of Force "U" in a memorandum to Rear Admiral Moon.[28]

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28. Annual Sanitary Report of Commander, Amphibious Bases, United Kingdom, for year ending 31 Dec. 1944, in files of Administrative History Section. In memorandum to Rear Admiral Moon, USN, dated 20 June 1944, the Force Medical Officer of Force "U" stated: "LST's apparently functioned satisfactorily as casualty carriers.... The number of casualties treated and carried by the LST's by individual ships and in the aggregate proved the basic soundness and value of fitting these ships for casualty handling."

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The LST's were augmented in their mission by four British hospital ships operating in the American section and by air evacuation which began on D plus 4 days. Hospital ships handled large numbers of wounded but they did not prove as practicable in evacuating casualties from the beaches as LST's because of the difficulty in loading them. The APA's were not actually used for evacuation of casualties but they, as well as men-of-war ships, returned with a small number of casualties which had been picked up at sea.

Small dispensaries were set up on the French beaches after the invasion. Naval advanced bases at Omaha and Utah Beaches were established on 12 July and as the ports became available larger facilities were established at Cherbourg on 15 July and at Le Havre later. Later, a dispensary was provided in Paris.

A medical unit landed on Utah Beach on D plus 4, proceeded overland with the Army and arrived at Cherbourg 26 June 1944. On 4 July 1944 the senior medical officer proceeded overland to Cherbourg to inspect the first-aid stations which had been set up there. The site selected was two miles from headquarters' offices in Cherbourg, located at Equerdreville, a suburb of Cherbourg. The building, in the shape of a "T", was of modern reinforced concrete construction. A G-5 medical component unit later reduced 50 percent in personnel was set up here in November of 1944. This "T" building occupied by the dispensary was a former school building previously

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occupied by the Germans for the same purpose. Much cleaning had to be done - the building was full of rubble and there were shell holes in the roof. On the fourth day the dispensary was sufficiently repaired to receive minor illnesses and injuries for bed care.

The patient bed capacity was 44 but the main dispensary could be expanded fully to 100-bed capacity, using the main building for patients exclusively. At the peak of its operation the staff constituted 8 medical officers, 30 pharmacist's mates and 15 non-medical rates. The case load increased progressively until the first week in September 1944 after which it gradually dropped below 50.

Surgical cases, including injuries due to enemy action, accidents from enemy explosives handled as souvenirs, acute appendicitis, and a small number of surgical procedures, made up the majority of patients.[29]

The dispensary was under the administrative direction of the Commander, U. S. Naval Forces in France, in turn under the Commander, U. S. Naval Forces in Europe, which looked to the higher echelons of the Commander, Twelfth Fleet, and conjunctively to the Chief of the Bureau of Medicine and Surgery.

In addition to the main dispensary, the medical activity at U. S. Naval Advanced Base, Cherbourg, also included two subsidiary

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29. Report of Medical Activity of U. S. Naval Dispensary, U. S. Naval Advanced Base, Cherbourg, France, dated 15 Sept. 1944, in files of Administrative History Section.

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dispensaries - one at headquarters and one in the arsenal Navy barracks, and a medical officer who performed the duties of port medical officer.

Small medical facilities were established in September at Naval Headquarters in Paris as well as at the Chateau de la Prunay, Louvecinnes, Seine-et-Oise, the residence of Commander, U. S. Naval Forces in France. The facilities at Omaha Beach were closed on 1 November 1944 and at Utah Beach on 19 November 1944, the equipment in each instance being returned to the medical storehouse.

A 50-bed dispensary was commissioned at LeHarve on 18 October 1944, and was served by U. S. Navy personnel until 29 June 1945. It was situated approximately two miles from the Navy Base Headquarters in a central location in relation to other Navy base installations. The dispensary occupied the buildings and grounds of a former French civilian maternity hospital which had suffered only slight bomb damage during the air raids that preceded the capture of LeHavre by the Allied forces.

Medical, surgical and dental care was provided by this dispensary to the personnel attached to the base, to nearby shore base activities and to ships and craft attached to the port of LeHavre. The main dispensary was closed 29 June 1945 with a reduction of the medical personnel from a G-7 to a G-9 unit. Further reduction to a G-11 unit 15 August 1945 left four hospital corpsmen

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at this activity.[30] Any personnel attached to this base or to the U. S. Navy ships operating in LeHavre which required further medical attention than that which could be rendered at the dispensary were taken to the 166th U. S. Army General Hospital.

Base Number 2, Roseneath, Scotland, was selected as the grouping point for medical department personnel in planning to assemble personnel and equipment for proposed medical department activities in Germany. The original planning called for a staff medical office consisting of staff medical officer, one Hospital Corps officer, and two hospital corpsmen to be established in Berlin. The ComNavForGer dispensary facilities were to consist of a 50-bed dispensary unit at Frankfort, Germany, and a similar 50-bed dispensary in Berlin. However, the war progressed so rapidly and terminated so quickly that considerable relocations of headquarters and realignment of command relationships took place and personnel requirements were reduced.

U. S. Naval Forces, France, was dissolved on 1 July and replaced by Naval Task Group, France, under ComNavForGer. The U. S. Group Control Council located its headquarters first in Hochst and later in Berlin. The administrative headquarters of ComNavForGer and Commanding General, U. S. Forces European Theater, were located in Frankfurt on the Main. As had been planned, Commander, U. S. Ports

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30. Supplement to Fourth Quarterly Sanitary Report of 1945 of the U. S. Naval Advanced Base, LeHavre, France, in files of Administrative History Section.
These four corpsmen cared for the base personnel since 15 Aug. 1945, averaging 168 enlisted men and 23 officers. This did not include Coast Guard personnel attached on small ships in this port.

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and Bases, went into Bremen and Bremerhaven where excellent accommodations were found in German military establishments.

The first echelon of the medical department at the U. S. Naval Advanced Base, Bremen, consisting of 2 doctors and 15 corpsmen, after a long trip moved into Bremen at the end of April 1945 and immediately started to get the sick bay space in order. The unit had followed the armies closely. Having departed from Number 2 Base, Roseneath, Scotland, on 1 April, they crossed the Rhine and arrived at Hengelo, Netherlands, 10 days later. The unit then moved on into Verdon, Germany, and 30 April 1945 it actually moved into Bremen, Germany, where four barracks buildings were selected for the sick bay.

The chain of evacuation for patients was through U. S. Army hospitals after the establishment of the unit in Bremen. In the latter part of May 1945 the setting up of U. S. Army 24th Evacuation Hospital and later in June the 115th Evacuation Hospital provided nearby facilities which were comparable to a general hospital.

The Navy Medical Department was given permission to use the laboratory of the Bremen City Hospital and its facilities for cultures, serology and all the usual specimen examinations.

The water supply was a constant problem. The water from the city of Bremen water mains was continuously contaminated. All water for drinking and culinary purposes was supplied in adequate amounts by tank trailers with chlorinated water.

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Diptheria was found to be epidemic in this area. Several mild or moderately severe cases were treated within the command with no complications and no serious threat of an epidemic in naval personnel occurred.

Venereal disease was a constant problem. Wide dissemination of infections in the female population, resulting as a consequence of free access to sex contacts in a conquered country, effected a high venereal disease rate. This was materially enhanced by men on various types of detached duty over Europe reporting as transients. [31]

The weakest phase of the medical program on this base was the failure to establish a rapid certain evacuation of naval patients from the base. Considerable delays were encountered in evacuating patients to the United States through Army channels of evacuation.

U. S. Naval Advanced Base, Bremen, was responsible to Task Group 124 or Commander, Naval Forces for Germany, which in turn was subordinate to Commander, Naval Forces in Europe. On 10 November 1945, U. S. Naval Advanced Base, Bremen, was decommissioned and its functions assumed by Commander, U. S. Naval Advanced Base, Weser River.

The senior medical officer with his main party arrived at Bremerhaven, Germany, 13 May 1945, to prepare a dispensary for

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31. Historical Supplement to Fourth Quarterly Sanitary Report for period of World War II of the U. S. Naval Advanced Base, Bremen, in files of Administrative History Section.

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use there at the earliest possible date. Five days later most medical departments were functioning smoothly with much enemy equipment which had been appropriated, including X-ray and physiotherapy apparatus. The activity was officially commissioned on 1 June 1945.

The aggregate personnel on the staff included 6 medical officers and 35 corpsmen. Approximately 1,400 U. S. naval personnel had access to the medical facilities and treatment of this dispensary.

There were no epidemics or outbreaks of food poisoning. Again, at this unit the venereal disease rate was high as a result of the wide dissemination of infection in the female population.[32]

As of 1 December 1945 the dispensary at Bremerhaven continued to function as a 31-bed capacity unit staffed by 2 medical officers, 1 dental officer and 12 hospital corpsmen. Administratively, it was subordinate to the Commander, Naval Forces in Germany, which, as has been indicated previously, was responsible to Commander, Naval Forces, European Waters, operating directly under Cominch.

At the headquarters, ComNavForGer in Frankfort on the Main, it had been intended to install a 10-bed dispensary with laboratory, X-ray, operating room and dental facilities. The personnel for this

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32. Historical Supplement to Fourth Quarterly Sanitary Report for period of World War II of U. S. Naval Advanced Base, Bremerhaven, Germany, in files of Administrative History Section.

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unit were transferred to Frankfort from Heathfield, England, by truck and ship via Exeter, Southampton and LeHavre. The headquarters was located in the Academy Building, a former German induction center. The medical officer in charge divided his time between the headquarters at Frankfort and the medical installations at Naval Technical Mission European Sub-base at Villa Lilly near Bad Schewalbach. He was assisted by a PhM 1/c on duty at each of these places.

In the Academy Building the medical department was assigned rooms for a dental office, clerical office, dispensary for holding sick call and a laboratory. This was adequate in view of the early cessation of hostilities. Cases that required bed care were sent to either 2nd General Army Dispensary or the 97th General Hospital. Naval personnel requiring 120 days' hospitalization were evacuated to the United States through the Army chain of evacuation.

The number of U. S. Navy personnel attached to the naval unit of the U. S. Group Control Council in Berlin was not sufficiently large to justify the establishment of a dispensary. A single hospital corpsman on independent duty in Berlin ministered to their health needs.

The complement of naval personnel on the continent was so drastically curtailed during October and November 1945 that the Naval Technical Mission European Sub-base at Villa Lilly was decommissioned. On 1 December 1945 the dispensary at Paris was closed. The medical

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department personnel were accordingly reduced throughout the European theatre. The dispensary at Bremen was turned over to the Army. Naval personnel who remained there were given medical attention by two hospital corpsmen at a one-room dispensary in the building housing the naval group. The functions of the U.S.N.A.B., Bremen, were actually assumed by the Commander of U. S. Naval Advanced Base, Weser River. The dispensary located at Bremerhaven continued to function as a 31-bed unit. U. S. Ports and Bases was decommissioned on 10 November and the remaining functions in that area were assumed by Commander, U. S. Naval Advanced Base, Weser River.[33]

The most effective portion of the local medical program under the command of United States Naval Forces, Germany, was the high standard of medical care and health maintained among the personnel during the many locale changes. The least effective portion of the program was the control of venereal disease which seems to have been symptomatic of the medical installation programs in the European theatre.

Section 4 Western Atlantic Medical Installations

The control and supervision of Trans-Atlantic Operations were delegated by the Commander in Chief, Atlantic Fleet, to Command Task Force 4. The number of this task force and all units therein

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33. Historical Supplement to Fourth Quarterly Sanitary Report of the U. S. Naval Forces, Germany, for World War II, in files of Administrative History Section.

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was changed from 4 to 24 on 6 March 1942. The Naval Operating Base, Iceland, was established as part of the command of Cominch, United States Atlantic Fleet on 6 November 1941. The Commandant, United States Operating Base, Iceland, exercised command over all U. S. naval shore activities, U. S. naval local defense forces and U. S. naval district craft in Iceland plus additional forces and units designated by Commander in Chief, Atlantic Fleet.

Camp Knox in the Reykjavik area, the headquarters of the Naval Operating Base, Iceland, was commissioned 16 May 1942 although half completed. A hut, under construction, served as a temporary sick bay with no bed space provided, but by July 1942 the medical department of Camp Knox was practically completed. The hospital-dispensary was composed of a group of 21 huts with 109-bed capacity housed in nine wards. In addition to the wards there were huts for X-ray, surgery, dental office, laboratory and pharmacy, dispensary, diet kitchen, isolation ward, recreation, and three storeroom huts.

During the subsequent months of 1942 it is interesting to note that only 25 percent of the admissions were of shore-based naval personnel in Iceland while approximately 75 percent of admissions were from ships operating in Iceland waters. The early sanitary reports commented on the very low percentage of venereal disease. No disease of epidemic proportions were indicated in these reports. The monthly sanitary report for July 1943, after experience of more than one year in Iceland, indicated that the incidence of disease was low; the diet

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was excellent, but the psychological effects of prolonged duty on personnel in Iceland were not favorable. There were many sub-clinical cases for psychosis and psychoneurosis. A tour of duty of one year was recommended.

This hospital-dispensary was centrally located, well staffed and well equipped to meet all the needs imposed upon it by Navy personnel stationed in Iceland and by ships operating in Icelandic waters. Auxiliary dispensaries were established at "Tank Farm" and Falcon Compores at Hoalford and at the Fleet Air Base in the Reykjavik area with adequate facilities to meet local needs. The medical supply for these units came directly from the Medical Supply Depot, Brooklyn, New York.

The morale problem was the most difficult one in the medical program of the station. Welfare and recreation facilities were inadequate in the early life of the base, but even later when these facilities were excellent a certain degree of mental unrest and depression was apparent.

These hospital-dispensary facilities were diminished and the number of medical and Hospital Corps personnel necessary to staff the hospital was markedly curtailed in correspondence with the diminution of the number of personnel on duty in this theatre and the gradually decreasing importance of their mission. By December 1945 this medical activity had been reduced to a 16-bed dispensary with an

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authorized complement of 2 medical officers, 1 dental officer and 10 hospital corpsmen. The dispensary is under the administration of the Commandant, United States Naval Operating Base, Iceland, which in turn was under the control of the Commander in Chief, Atlantic Fleet, part of the command of Cominch.[34]

An advanced detail of a Marine detachment arrived in Burmuda, February 1941. The detachment officially established in March eventually had a sick bay adequate for the number of men in the camp. In the early part of 1941 the United States Naval Operating Base, Bermuda, became a reality. During the first years of the Naval Base's existence there was much confusion and duplication of effort, because there were many dispensaries at this base functioning under various commands. An effort was made to consolidate the medical facilities in May 1943. All dispensaries were to cease to exist as independent units and their personnel were to perform only under the Naval Air Station. The Naval Mobile Base Hospital Number 1 was decommissioned in October 1943 and the Construction Battalion Hospital ceased to function after January 1944. The Naval Air Station Dispensary, commissioned 29 May 1943, absorbed the medical activity of both of these facilities. There was further consolidation 15 January 1945 when the present Naval Air Station Dispensary became the Naval Operation Base Dispensary with branch dispensaries at the Naval Air Station, Anti-Aircraft Training Center,

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34. Historical Data to Quarterly Sanitary Report of the U. S. Naval Operating Base, Camp Knox, Iceland, for the period of World War II, in files of Administrative History Section.

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the Submarine Repair Facility - Ordnance Island and the Shore Patrol headquarters. All personnel and all medical department property accounts were transferred to the Naval Operating Base Dispensary. The senior medical officer at the dispensary was given the additional duty as the Base Medical Officer. The branch sick bays, with the exception of the Shore Patrol first-aid station, were all closed as eventually the need for them diminished.

The functions of the Naval Operating Base dispensary have been to administer, to maintain and procure facilities for the care and treatment of the sick and injured and to operate the dispensary in accord with the requirements of the Navy Regulations and the Manual of the Medical Department.

Prior to the commissioning of U. S. Naval Operating Base dispensary, 29 May 1943, medical department facilities consisted of a sick bay at the Naval Air Station, a sick bay at the U. S. Naval Operating Base and a sick bay at Kinley Field on the eastern end of the island. As indicated, these activities were consolidated with the commissioning of the dispensary at the United States Naval Air Station, Bermuda.

In the early phases of the War the dispensary furnished emergency medical treatment to survivors rescued from ships that were torpedoed in the vicinity of Bermuda, and it also furnished hospitalization for prisoners of war that were rescued from a German

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submarine.[35] Many members of Allied navies who were in Bermuda had been hospitalized from time to time.[36] During the training of the DD-DE shakedown task group, the dispensary furnished all newly commissioned vessels with emergency supplies and equipment. Hospitalization was furnished for personnel of all ships that were not adequately equipped or when a long period of hospitalization was necessary. There was an average of 100 patients on the sick list daily during 1944.

Mosquitoes have been a major problem at this base. A well supervised campaign for the eradication of the mosquito was launched early in 1942 and with the full cooperation of the Bermuda Health Authorities the mosquito control program was successful. There was considerable trouble with fungus infection at the base. An unfortunate series of gastro-intestinal conditions in the summer of 1941 was attributed directly to flies. Cooperation with the various health authorities in Bermuda was successful in keeping venereal disease at a minimum. The local supply of milk was a real problem from the

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35. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for period of World War II of Bermuda, British West Indies, in files of Administrative History Section.
There were 18 admissions of German prisoners of war, totaling 375 sick days. There were 101 admissions of the enlisted personnel of the Italian Royal Navy officers with a total of 902 sick days and 6 admissions of Italian Royal Navy officers with a total of 49 sick days.

36. Ibid., Members of the Allied Naval Services included 16 admissions of the French Navy with a total of 171 sick days and two admissions of French officers with a total of 15 sick days.

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conception of the base, and the sole reliance on rain water for fresh water created the exercise of extreme vigilance to prevent the wasting of water.

U. S. Naval Mobile Base Hospital Number 1 was established by order of the Secretary of the Navy, dated 9 September 1940.[37] This hospital was mobile to the extent that it was transported from New York and was readily established to receive a limited group of patients on the fifteenth day after arrival in Guantanamo Bay. In less than two months after its arrival, 30 October 1940, it had definitely become less mobile as more machinery was set up on concrete foundations and more buildings replaced the tents originally set up.

By far the greatest number of patients of this hospital had come from the Fleet Marine Force. When this force was withdrawn from Guantanamo Bay, Cuba, the number of patients cared for by the hospital diminished rapidly. This experimental project, the first of its kind, was very successful. The lessons learned on the corals of Guantanamo later paid untold dividends in human lives on the atolls of the Pacific.

The dismatling orders were received June 1941 and immediately the work of dismantling the hospital buildings was started and completed 18 July 1941. The few remaining patients on hand were transferred to

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37. The following is quoted from the order: "U. S. Naval Mobile Base Hospital Number One....will be established on 5 October 1940 as a part of the organization of the U. S. Fleet and will be assigned to the command of Commander Atlantic Squadron."

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the Naval Dispensary, Guantanamo Bay. The crated Hodgson prefabricated buildings were placed on board the USS DELTA for transfer to Bermuda. Altogether 381 truckloads of material were transported.

The hospital arrived in Bermuda 23 July 1941 and on 28 August it was formally opened and received its first patient.[38] The training that the personnel had received in erecting the hospital in Guantanamo Bay was invaluable. They were experienced, acclimated and capable. The new construction achieved proved to be far superior to its predecessor in Guantanamo. It was located at Riddell's Bay, Warwick Parrish, about six miles outside the city of Hamilton. The tents and prefabricated buildings had been set up and equipment installed again in Bermuda.

At the peak of its activity there were 20 officers, 160 rated corpsmen and 17 non-rated men attached to the hospital. There were 225 beds ready for use which could be increased to 500 on short notice by setting up tents. The ward beds, cabinets, linen and all equipment were of good quality and sufficient in quantity to care for a total of 300 patients. Early in 1942, steel frame buildings replaced some of the prefabricated ones.

This unit carried on its work effectively for a little more than two years on Bermuda soil. In this time it cared for patients at-

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38. Sanitary Report of the U. S. Naval Mobile Base Hospital No. 1 for the Calendar Year 1941, in files of Administrative History Section, p. 7.

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tached to the United States Army, the Navy, the Marine Corps, the Merchant Marine, dependents of naval personnel, injured merchant men of the Allied Nations, the Royal Navy Ferry Command, and the sick and injured Civil Service or civil employees.

Although Bermuda has a subtropical climate, it is remarkably free of infectious diseases of this group. There were no cases of malaria among the personnel, none of yellow fever or dengue in 1942, and food and water-borne diseases were entirely absent. Venereal infections were few and they were not a serious problem among personnel of the staff.

This hospital was decommissioned by order of the Chief of Naval Operations dated 27 September 1943. The need for the Navy's first mobile unit no longer existed with the completion of the modern dispensary at the Naval Air Station and the Army Hospital at Fort Bell. Patients were transferred to either of these two facilities. Forty-one medical personnel and a good portion of the medical and surgical supplies and equipment were transferred to the new U. S. Naval Air Station dispensary. The hospital was officially demobilized on 30 October 1943.[39]

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39. Annual Sanitary Report of the U. S. Naval Mobile Hospital No. 1, Bermuda, for Calendar Year 1943, in files of Administrative History Section. The Bureau of Medicine and Surgery directed that "such supplies and equipment as may be required by the Naval Operating Base or by other Medical Department facilities in Bermuda be transferred to those facilities for their use."
The Commandant of the Naval Operating Base directed that "all the steel buildings and all rolling stock be transferred to the Naval Operating Base, and all the supplies be turned over to the various activities desiring such material."

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The medical installations in Bermuda were under the administrative supervision of the Commander-in-Chief, Atlantic Fleet, which in turn was directly under the Chief of Naval Operations.

The Naval Operating Base dispensary at Guantanamo Bay, Cuba, served as a hospital for both the base and fleet units in the area. Cases that required prolonged hospitalization were transferred to the U. S. Naval Hospital, Key West, Florida, for further treatment and disposition. All the base medical activities came under the direction of the Commander, Naval Operating Base, and the base medical officer who in turn came under the administrative supervision of the Commandant, Tenth Naval District and the district medical officer. The consolidation of all base medical activities under the base medical officer, effective as of September 1944, proved very effective in making a more efficient medical organization under a central control with a minimum waste of time, effort and manpower.

This dispensary hospitalized survivors from sunken vessels during the early days of the war when submarine warfare was rife in the Caribbean area. The base itself was a most important staging area in the formation of convoys bound for both the European and Pacific theaters from the early days of the war to V-E day. The Medical Department contributed to the successful completion of these missions in rendering hospitalization, medical care and medical supplies to both naval and merchant vessels visiting this port. A small port dispensary,

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established early in 1942 to care for merchant seamen and crews of yard craft, was decommissioned in May 1945. During this period the patient load averaged 100 patients at the naval station dispensary, having reached a peak of 140 patients in January 1943. The patient load increased steadily after V-E day when the Atlantic and Guantanamo Bay area was made a training area. This was true until V-J Day, after which, of course, a sharp decline was evident.[40]

Malaria was not a major problem at this base as a result of the efficiency of the malarial control program and the limited rainfall in this particular area. The incidence of venereal disease in the admissions to the sick list at this activity was effectively reduced through control measures from a venereal disease rate of 138 annual per thousand in 1941 to a drop of 58.72 in 1944.

By order of the Secretary of the Navy, the U. S. Naval Hospital, San Juan, Puerto Rico, was commissioned 1 December 1943. The hospital has been in continuous operation since that time. After a reduction from the original number the operating staff included 8 medical officers in addition to the commanding and executive officers, 9 nurses, 4 Hospital Corps officers and 84 enlisted personnel.

Military personnel of the Navy, Marines, Coast Guard and of the U. S. Merchant Marine, and occasionally members of the naval service of allied forces, were hospitalized. The patient census

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40. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative for Period of World War II, of U. S. Naval Operating Base Dispensary, Guantanamo Bay, Cuba, (dated Nov. 1945), in files of Administrative History Section.

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reached the peak load of 210 by April 1944. However, this hospital census was appreciably reduced after April with the changing tide of events in the course of naval warfare in the Atlantic and in the European theatre of operations with consequent reduced naval activity in this area. By July 1945 the patient census had dropped to a daily average of 41. Most of the patients admitted in 1944 were from the San Juan area. There were other admissions from the Caribbean islands, particularly the Virgin Islands, Antigua, and Aruba, we well as Coast Guard personnel cases, afloat and ashore. In addition, there were frequent medical and surgical emergencies from ships in the port of San Juan.[41]

More specifically, this hospital acted directly as a receiving hospital for all patients in the area requiring hospitalization whose duty status included them within the plans and directives of the Commandant, Tenth Naval District. Patients who recovered from their infirmities were promptly returned to duty, while those whose conditions required protracted care and treatment were evacuated to the nearest naval hospital in the United States, via plane or ship transport as available.

This activity was located in the country approximately seven miles from the city proper. The long one-storied, partially hurricane-

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41. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II of U. S. Naval Hospital, San Juan, Puerto Rico, in files of Administrative History Section.

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proof buildings were built on a hill facing northwest. The artifically prepared ditch system which supplemented the natural drainage helped to prevent pooling of stagnant water. The nearest adjacent swamp-land was under mosquito control. There were two separate water supplies, one for the hospital and its buildings and the other for the wing quarters. Both were chlorinated and tested each week in the laboratory for potability.

During 1944 there were numerous diarrhea and dysentery cases. Although they never assumed epidemic proportions and no fatalities resulted, the admissions to the sick list were numerous. No further problems of this nature resulted when these cases were traced to one source of milk which was found to contain paratyphoid germs because of non-pasteurization. Malaria has not been of particular significance in this area due primarily to the anti-malarial cases of infectious jaundice, and venereal disease had a low incidence. The sanitary reports attributed this to a program of prostitute medical control, prophylaxis and immediate treatment. Other deviations of disease incidence at this unit were attributed to disease indigenous to the tropics such as filariasis.[42]

The commanding officer of the hospital was under the overall command of the Commandant, Tenth Naval District, and directly under the district medical officer of the Tenth Naval District. For

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42. Annual Sanitary Report of the U. S. Naval Hospital, San Juan, Puerto Rico, for the year ending Dec. 1944, in files of Administrative History Section, pp. 21-22.

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a ten-month period from September 1944 to July 1945 the commanding officer of the hospital was the district medical officer of the district. In a collateral sense the hospital was under the Bureau of Medicine and Surgery and the Commander, Caribbean Sea Frontier, as well as an independent command under the jurisdiction of the Commandant, Tenth Naval District; it in turn fell under the administrative control of the Chief of Naval Operations.

A directive of the Chief of the Bureau of Medicine and Surgery of July 1945 authorized the availability of 100 beds for hospitalization of Veteran Bureau patients. These patients, admitted through the authority of the Regional Direction, Veterans' Administration, San Juan, Puerto Rico, presented new problems to the hospital. The greatest of these problems was the language difficulty, for approximately 65 percent of the veterans were Puertoricans who spoke only Spanish and understood no English. In the historical supplement to the fourth quarterly sanitary report the commanding officer recommended that this hospital be turned over to the veterans for the hospitalization of Veteran Bureau patients.[43]

The medical department at U. S. Naval Station, Roosevelt Roads, Puerto Rico, was established 12 December 1941. Two detachments arrived on that date - one was stationed at Roosevelt Roads

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43. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II of U. S. Naval Hospital, San Juan, Puerto Rico. It was advocated on the basis that the small number of naval personnel in the area could be served adequately by the dispensary at the Naval Air Station.

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and the other on Vieques Island, Vieques Sound, Puerto Rico. A 30-bed hospital was build on Vieques Island, but later the hospital was moved to Roosevelt Roads and became a dispensary when the bulk of the activity was shifted to that station.

This 32-bed dispensary at Roosevelt Roads was officially commissioned 1 October 1943 with a complement of 5 medical officers, 1 dental officer and 35 hospital corpsmen, and later, an additional 4 Navy nurses. During 1943, when submarine warfare was active in these waters, this medical activity was fully prepared to care for possible battle casualties or survivors. However, the medical activities were comparatively limited. The bulk of treatment and hospitalization was for naval and civilian personnel attached thereto. Patients who needed surgical or specialized medical care were transferred to the U. S. Naval Hospital, San Juan, Puerto Rico. The malaria control program, in an area which is endemic for malaria, was very successful.[44]

The 32-bed dispensary was closed September 1944 and a 7-bed dispensary was opened in the barracks area with a reduced complement. This unit was under the commanding officer of the U. S. Naval Station at Roosevelt Roads who was under the jurisdiction of the Commandant, Tenth Naval District, functioning in turn under the administrative supervision of the Chief of Naval Operations and

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44. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II for U. S. Naval Station, Roosevelt Roads, Puerto Rico, in files of Administrative History Section.

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in a subordinate connection to the Bureau of Medicine and Surgery and the Commander, Caribbean Sea Frontier.

The medical department of the U. S. Naval Base, Corinto, Nicaraqua, was commissioned on 20 January 1943. The staff at that time constituted 2 medical officers, 1 Hospital Corps officer, and 3 pharmacist's mates. The medical department was directly responsible to the district medical officer of the Fifteenth Naval District and the staff medical officer of the Naval Air Bases as of 1 January 1945. At this time the station was changed to the command of the Commander Naval Air Bases.

Many evacuation cases were cared for by this activity. A squadron plane or crash boat was immediately sent to the scene with a medical officer aboard to answer a call received by communication from an allied ship at sea where an acutely sick or injured man was aboard. The venereal disease rate decreased very favorably among the personnel at this activity after a prophylaxis station was put into use and the cooperation of the Nicaraquan authorities was secured in effective control measures. Two Hospital Corps officers brought the malaria rate down to a minimum through their diligent work.[45]

The Coco Solo Naval Hospital Reservation consisting of a land grant of 39.4 acres from the Panama Canal Zone was established

45. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II of U. S. Naval Air Base, Corinto, Nicaraqua, in files of Administrative History Section.

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by Presidential Decree on 17 December 1941.[46] Ground was broken for the hospital construction on 1 September 1941 and all building construction was completed 1 September 1943. The hospital was commissioned on 1 September 1942 by order of the Commandant, Fifteenth Naval District. Two months later patients were admitted and subsequently the hospital has been in continuous operation.

This hospital is an activity of the Naval Operating Base, Coco Solo, Canal Zone. The commanding officer is subordinate to the Commander, Naval Operating Base, Coco Solo, Canal Zone, for purposes of military administration. He is directly under the Commandant, Fifteenth Naval District, and in turn under the Chief of Naval Operations. The hospital is conjunctively, as in the case of the Naval Hospital at San Juan, Puerto Rico, under the administrative command of the higher echelon, the Bureau of Medicine and Surgery.

This hospital had a 357-bed setup which had a maximum possible expansion to 573 beds. The patient load on the medical service varied from 175 to 200. There were 3 medical officers on this service, 2 interns and a psychiatrist. The laboratory and chief of medicine activities were combined. The surgical service had 4

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46. Sanitary Report of the U. S. Naval Hospital, Coco Solo, Canal Zone, for the Calendar Year 1943 in files of Administrative History Section. The land grant was situated between the old Cativa Road and the present Trans-Isthmian Highway, a distance by road four miles from the Naval Station, Coco Solo, Canal Zone. The terrain is rolling in character and has a minimum elevation of 54 feet above sea level.

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medical officers, including the chief of surgery, orthopedic surgeon, eye, ear, nose and throat specialist and urologist, caring for a patient load of 160 to 175. During the war years the staff complement varied. There were on an average 11 medical officers, 1 dental officer, 4 to 10 Hospital Corps officers, 16 to 19 nurses, 1 disbursing officer, and enlisted personnel varying from 162 to 179.

In spite of the handicaps of weather and situation, this hospital had provided excellent medical care for over 3,000 patients a year since its commissioning. Patients who were received at the hospital were referred from the dispensaries of various naval activities in the vicinity, and also from ships docking on the Atlantic side of the Canal. Many patients had been referred for special examinations or special treatments and were then handled as out-patients without admission to the hospital.

After the dependents of naval personnel arrived in this area, a dependents' ward and out-patient service was authorized on 14 June 1945. This ward afforded treatment for all medical or surgical conditions except chronic or infectious diseases.

The number of hospital admissions was divided about equally between the medical and surgical services. No epidemic disease except malaria occurred at the hospital. Malaria was an ever-present menace and it occurred in numbers approaching an epidemic among members of the staff during the wet season of the year, especially

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through September, October and November.[47] Intensive measures were undertaken to eradicate the infected anopheles originating in the Cativa district, one mile distant from the hospital, and strict malaria discipline was in effect at the hospital.

The incidence of acute respiratory diseases was low. Gastro-enteritis was among the commonest medical disease treated. The number of gonorrhea infections dropped from 20 cases per month on the urological service to 2 or less after penicillin therapy was instituted.[48]

The accompanying charts show the administrative organization of the hospital, as of 1 September 1942, and the existing organization as of 1 August 1945.

The U. S. Naval Hospital, Balboa, Canal Zone, was commissioned on 15 August 1942. This activity functioned as a general hospital and a unit of the Naval Operating Base, Balboa, Canal Zone, in

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47. Supplement to the Fourth Quarterly Sanitary Report of the U. S. Naval Hospital, Coco Solo, Canal Zone, for the Calendar Year of 1945. In 1943, 15 cases of malaria were treated at the hospital; 8 of these were members of the hospital staff. In 1944, 54 cases of malaria were admitted, and 11 of them were from the staff. In 1945, 50 cases were admitted, 14 of them staff personnel. Approximately 10 percent of the cases are of the malignant tertian or mixed malignant and benign tertian types.

48. Sanitary Report of the U. S. Naval Hospital, Coco Solo, Canal Zone, for the Calendar Year 1944, in files of Administrative History Section.

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the Fifteenth Naval District. This was a 350-bed hospital organization with a complement of 11 medical officers and 12 nurses. The hospital corpsmen complement varied between 118 and 131, and the number on board varied from 120 to 185. The daily patient census of this activity averaged about 200. From 15 August 1942 to 31 August 1945 the number of patients admitted totalled 6,425, including 470 officers.[49]

This hospital was staffed and equipped to deal with every type of medical and surgical problem except brain operations and cases requiring roentgen therapy, which services were available at the naval hospital at Coco Solo, Canal Zone. Patients who needed protracted care were transferred to a naval hospital in the United States. Certain misfit cases, principally of a neuropsychiatric nature, were received in larger percentage than usual since this hospital was the last U. S. naval hospital available for many of the ships going to the Pacific.

In general, the clinical material differed little from t found in a civilian hospital. No acute traumatic or mental cas were treated, as Panama was not a combat theater. However, c induced conditions in the chronic stage formed perhaps 10 percen of the hospital population. Fungus infection of the skin was very common

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49. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II, of U. S. Naval Hospital, Balboa, Canal Zone, in files of Administrative History Section.

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but most cases yielded easily to treatment. No tropical diseases are considered endemic in Panama. The number of cases of malaria treated was relatively small; some of these treated represented relapses of malaria acquired in the Pacific. The incidence of venereal infection was low because of the rigid venereal control exercised by the U. S. Army and the facilities for prophylaxis.[50] The hospital also had a dependents' service with available gynecologic, obstetric and pediatric services.

The commanding officer of the hospital was subject to the Commander, Naval Hospital, Balboa, Canal Zone, who was under the administrative authority of Commandant, Fifteenth Naval District, who, in turn, was under the command of the higher echelon of the Chief of Naval Operations and collaterally under the supervision of the Bureau of Medicine and Surgery.

The U. S. Naval Ammunition Depot sick bay at Balboa, Canal Zone, was organized as a part of the Naval Ammunition Depot which had been commissioned 8 September 1937. It functioned as a 3-bed unit of the Naval Operating Base, Balboa, Canal Zone, in the Fifteenth Naval District. The medical officer of this dispensary was attached to the Naval Operating Base dispensary.

The U. S. Naval Dispensary, first known as part of the

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50. Sanitary Report of the U. S. Naval Hospital, Balboa, Canal Zone, for the Calendar Year 1944, in files of Administrative History Section.

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Section Base, N.O.B. and later as part of the U. S. Naval Station, Balboa, Canal Zone, was officially put into commission on or about September 1941. The medical department in the beginning was composed of two units, one in the Marine barracks and another in the administration. The present Naval Station Dispensary was commissioned in 1941 and the administration area dispensary became known as the Marine Dispensary which continued until September 1945.

This U. S. Naval Station Dispensary at Balboa, which had been set up before our entrance into the War, played a very important role in providing medical care for increasing numbers of service personnel of the Navy, Marine, Coast Guard and Merchant Marine, as well as civilian Navy employees on the base. Although it did not actually fill the role of a combat unit, it was prepared to do so. This activity did play a significant part in the defense of the area by protecting the health of base personnel, particularly in the submission of malaria, by providing efficient medical attention and first aid to military personnel in transient status and by always being prepared to act as an emergency hospital in the event of bombing or invasion.[51]

Shortly after the Naval Operating Base, Trinidad, had been opened, 24 March 1941, a small dispensary was established at the

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51. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report of the Period of World War II of U. S. Naval Operating Base Dispensary, Balboa, Canal Zone, in files of Administrative History Section. Only 12 cases of primary malarial infection were seen at the unit during the war years.

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Naval Operating Base Headquarters in Port of Spain, 12 miles from the site of the base. In this primitive setting in Trinidad, public health, hygiene and sanitation, and the care of the sick presented difficult problems. Malaria, gonorrhea, and syphilis had a high rate in the native population. Typhoid fever, bacterial and amoebic dysentery and filariasis were common. In October 1941 two temporary dispensaries were established for the Naval Air Station and the Marine detachments. In June 1942 when the Section Base was commissioned, a dispensary was provided for the west end of the base. This dispensary assumed the task of medical care for these crews, in addition to the regular work of the base.

Finally, on 17 October 1942 a new 40-bed permanent Naval Air Station Dispensary was completed on 17 October 1942. It was a fine structure with well ventilated wards and offices, and wide corridors and porches. It began functioning as a temporary hospital for the base. On 9 August 1943, 160 patients were accommodated in this 40-bed dispensary. Crowded shower rooms and heads were the worst violations of rules against overcrowding in this hospital.

The various commands were widely distributed over this base. The Naval Operating Base Headquarters was at Port of Spain. The Naval Air Station was in the Carengo Bay area. There were the Escort Vessel Repair Base, the Naval Supply Depot, the Net Depot, the 30th Construction Battalion, the 80th and 83rd Construction Battalion, the Section Base with its scores of escort vessels and the Naval Air

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Auxiliary Field. The Naval Air Station Dispensary, the Section Base Dispensary and the naval hospital were the only medical units set up for the medical care, other than first aid, for the personnel on the stations. Each of these medical units had its own medical officers and hospital corpsmen. Small wards were equipped for each unit to care for the sick and injured on the station. Hospital cases were transferred to the naval hospital. The medical department of each of these commands functioned as a well equipped, efficient and independent unit within its own command. The normal routine functions of these medical units, dispersed as they were over the base, served for first-aid and dispensary service for the entire base. The dispensary at the Naval Air Station assumed the functions of the naval hospital when it was decommissioned 23 August 1945.[52]

This hospital in Trinidad, the fourth of the hospitals located in the Caribbean area or the "outer ring of defenses of the Panama Canal," was designated the U. S. Naval Hospital at the U. S. Naval Operating Base, Trinidad, British West Indies. This was the only one of the four erected on land in British colonial territory granted under the 99 year lease by the Anglo-American Leased Bases Agreement of 27 March 1941.

The hospital was planned as a 360-bed hospital and was

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52. History of the U. S. Naval Air Station Dispensary, Naval Operating Base, Trinidad, British West Indies, in Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II, dated Nov. 1945, in files of Administrative History Section.

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so designated. This number of patients could readily be accommodated without crowding. Plans were prepared to expand the bed capacity to 500, in case of necessity. The hospital was commissioned 12 August 1943 and since this date the hospital has never been filled to capacity. The maximum number of patients in any one day was 300.

The staff of this hospital constituted 15 medical officers, 2 dental officers, 2 Hospital Corps officers, 1 chief pharmacist, 2 pharmacists 8 nurses, 136 hospital corpsmen and 41 other naval personnel. It was not until several months after the commissioning that the hospital was finally completed.

In the early stages of World War II, the possibility of an enemy attack on the defenses in this area was anticipated. This hospital would have been called upon to provide treatment for battle casualties in the southern Caribbean sector if such an attack had occurred. Since there were no major attacks, the mission of the hospital was resolved in furnishing routine care and treatment for the sick and injured of the Caribbean area. Patients were received from local naval authorities as well as from outlying naval bases and ships. Patients admitted to this hospital came from many different sources and included a wide variety of personnel, numbered around 8,000 not including those from ships which put in at Trinidad.[53]

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53. Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II, for U.S.Naval Hospital, Naval Operating Base, Trinidad, British West Indies, in files of Administrative History Section. Patients admitted to the hospital included the personnel of the U. S. Army, Navy, Marine Corps and Coast Guard, members of the armed services of

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The health of the naval personnel at this base was excellent. During the main portion of the hospital's history there was a total absence of the diseases common to tropical climates as malaria, dysentery, dengue fever, etc., in the hospital staff and only a few cases were admitted to the hospital. Malaria control for the hospital was handled by the base malaria control unit and was very effective except for minor breaks. Many of the patients treated for venereal disease had been exposed and infected in Brazil and other South American countries. Hence a great many had received treatment prior to admission. Venereal disease was not high at this activity.

This hospital was disestablished and placed in a maintenance status on 23 August 1945. The functions of the hospital were taken over by the Naval Air Station Dispensary at the base.

In January 1942 a naval medical officer was assigned to duty at the U. S. Naval Attache's office, Rio de Janeiro to make a sanitary survey of the proposed sites for naval air stations and naval observatories, along the coast of Brazil from the north to the south. Also, the medical officer provided medical services to naval personnel in Rio de Janeiro area.

At the Naval Air Station at Belem, Brazil, there was an 18-bed dispensary with one medical officer. Mosquito control work was

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all the Allied Nations, American Merchant Seamen, beneficiaries of the U. S. Employees' Compensation Law, other Federal employees and certain other classified civilians.

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highly effective there. The first-hand accounts indicated that it was clean and adequate but lacked surgical equipment. This necessitated the performance of all surgery by the Army.[54]

Because of the urgent need of dental treatment for the numbers of the Armed Guard crews whose ships visited this port, a dental officer was assigned to duty at this medical activity, June 1945.

With the expansion of the Naval Air Station at Natal, Brazil, a small dispensary was established at the naval air station. This dispensary of ten beds was adequate in view of the fact that there was an Army station hospital almost adjacent which cared for all seriously ill patients.[55]

The medical activities of these units along the coast of Brazil were of a wholly routine nature. There were no problems of epidemiology, tropical disease, or unusual cases. An appreciable amount of the medical officer's duties was that of liaison officer between the medical departments of the U. S. Navy and those of the Brazilian Air Force and Brazilian Navy, in subjects relating to organizational planning and expansion of the Brazilian Air Force and the Brazilian Navy. These medical units were under the command of the U. S. Naval Operating Base, Navy 153, which had been established

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54. Rear Adm. Luther Sheldon, Jr., (MC), USN, to Chief of BuMed, BuMed A-EC of 29 Dec. 1943 L5-3/EF(124), Report of Temporary Additional Duty.

55. Ibid.

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as an integral part of the South Atlantic Fleet and Commander in Chief, Atlantic Fleet, in turn operating under the administrative supervision of Chief of Naval Operations and collaterally under the direction of the Bureau of Medicine and Surgery.

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MEDICAL DEPARTMENT FACILITIES IN OPERATION IN THE
TENTH NAVAL DISTRICT
AS OF JANUARY 1945

ACTIVITY	BED CAPACITY	OFFICERS				ENLISTED
		MEDICAL CORPS	DENTAL CORPS	HOSPITAL CORPS	NURSE CORPS	HOSPITAL CORPS
BRITISH WEST INDIES						
Antigua (N.A.A.F.)	2	0	0	0	0	1
Great Exuma (N.A.A.F.)	4	0	0	0	0	2
Trinidad						
Hospital	290	9	2	5	8	93
Naval Operating Base		8	4	2	0	45
NAS Dispensary	66					
Repair Facility Disp.	0					
Civilian Emp. Disp.	0					
CUBA						
Guantanamo Bay						
Naval Station	220	9	5	2	6	58
Naval Air Station	16	2	1	0	0	18
Marine Corps Base	8	1	1	0	0	7
A.A.T.C.	0	0	0	0	0	2
Net Depot	0	0	0	0	0	1*
PUERTO RICO						
Roosevelt Roads (NavSta)	7	1	0	0	0	5
San Juan						
Naval Hospital	200	9	1	4	9	71
Naval Air Station	39	7	6	1	0	33
Drydock & Repair Fac.	0	0	0	0	0	4
Frontier Base	0	0	1	0	0	4
Sup. Radio Sta. (Carolina)	0	0	0	0	0	2
Gunnery Range	0	0	0	0	0	1
NAD, Sabana Seca	0	0	0	0	0	1
Aux. Radio Sta. (Martin Pena)	0	0	0	0	0	0#
First Aid Station	0	0	0	0	0	1

(* This man is also included in Naval Station complement as he is only on temporary duty at Net Depot)

(# Hospital Corpsmen from Drydock & Repair Facilities hold sick call daily at Aux.Rad. Sta.)

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PUERTO RICO (Continued)						
Vieques Island (N.A.D.)	0	0	0	0	0	1
NETHERLANDS WEST INDIES						
Aruba	0	0	0	1 Ch.Pharm	0	0
Curacao (Naval Camp)	25	2	1	0	0	11
(Hato Field - Hedron Det.)		1	0	0	0	6
VIRGIN ISLANDS						
St. Thomas						
Naval Station	10	1	0	0	0	6
Sub. Base	0	0	0	0	0	0

(Hospital Corpsmen from Naval Dispensary, Naval Station, hold sick call daily at Submarine Base)

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MEDICAL DEPARTMENT FACILITIES IN OPERATION IN THE FIFTEENTH NAVAL DISTRICT

AS OF 1 JANUARY 1945

ACTIVITY	BED CAPACITY	OFFICERS				ENLISTED
		MEDICAL CORPS	DENTAL CORPS	HOSPITAL CORPS	NURSE CORPS	HOSPITAL CORPS
CANAL ZONE						
Balboa						
Naval Hospital	350	11	2	4	14	153
Dispensary (Naval Station)	8	3	2	1	0	22
Marine Sick Bay (Annex to Naval Station)	14	1	0	0	0	5
Sick Bay, Naval Ammunition Depot	4	0	0	0	0	4
Dispensary (Hdqtrs., 15th Nav.Dist.)	0	3	1	0	0	16
District Medical Office	0	1	0	2	0	4
Coco Solo						
Naval Hospital	464	11	1	4	16	167
Dispensary (Naval Station)	30	5	4	0	0	43
Dispensary (Cristobal Annex to Nav. Station)	4	2	0	0	0	8
Dispensary, Naval Air Station	90	4	3	1	0	45
Farfan						
Sick Bay (Radio Station)	5	0	0	0	0	2
Summit						
Sick Bay (Radio Station)	0	0	0	0	0	2
Taboga Island						
Dispensary (Nav. Station)	20	1	1	0	0	6

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Outlying Bases, 15th Naval District						
Galapagos Island						
Dispensary (Naval Base)	15	1	1	0	0	11
Puerto Castilla, Honduras						
Dispensary (Naval Base)	14	1	0	0	0	7
Corinto, Nicaragua						
Dispensary (Naval Base)	16	1	0	1	0	8
Baranquilla						
Dispensary (Naval Base)	4	0	0	0	0	1

MEDICAL DEPARTMENT FACILITIES IN THE SOUTH ATLANTIC AREA

(THE FOLLOWING TO BE ESTABLISHED ACCORDING TO PLANNING DIVISION - AUGUST 1945)

BRAZIL

	NO. OF BEDS
CARVELLAS	
Dispensary	10
MACEIO	
Dispensary	11
RECIFE	
Medical Supply Storehouse No. 10	0
RIO DE JANEIRO	
Dispensary (Naval Operating Facility)	8
SANTA CRUZ	
Dispensary	15
Total	44

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APPENDIX A

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STATISTICAL MONTHLY REPORT OF ADMISSIONS

Medical and Surgical Cases Treated at U.S. Naval Base Hospital No.12.

Period: 1 March - 30 September, 1944.

SERVICE	March	April	May	June	July	Aug.	Sept.	TOTALS
AMERICAN								
U. S. Navy	116	117	266	635	607	529	596	2,886
U. S. Army	13	3	3	1,251	1,094	547	2,274	5,185
U. S. Coast Guard	0	0	18	18	22	55	43	156
U. S. Merch. Marine	2	0	1	1	3	0	3	10
BRITISH								
Royal Navy	4	2	13	13	6	3	5	46
Royal Army	435	289	236	162	6	6	12	1,146
Canadian	0	8	18	22	0	0	8	56
FREE FRENCH	0	0	0	2	1	1	30	34
PRISONERS OF WAR	2	4	1	2	0	116	0	125
CIVILIANS								
American	0	0	1	0	0	0	1	2
British	0	0	1	1	1	0	0	3
T O T A L S:	572	424	558	2,107	1,740	1,257	2,972	9,630

Total number of U. S. Navy personnel evacuated (including 80 by air) ---------- 1,055

Total number of U. S. Army and Allies evacuated -- 5,192

TOTAL EVACUATED: 6,247

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B I B L I O G R A P H Y

MEDICAL INSTALLATIONS IN THE ATLANTIC AREA

Manuscript Materials

I. Sanitary Reports

Annual Sanitary Report of Commander Amphibious Bases, United Kingdom, for Year Ending 3 December 1944.

Annual Sanitary Report of the Commander, Twelfth Fleet, for Year Ending 31 December 1944.

Annual Sanitary Report of the U. S. Naval Base Hospital No. 5, Casablanca, for 1943.

Annual Sanitary Report of the U. S. Naval Base Hospital No. 5, Casablanca, for 1944.

Annual Sanitary Report of the U. S. Naval Base Hospital Number 9, Oran, Algeria, for Calendar Year 1943.

Annual Sanitary Report of the U. S. Naval Base Hospital Number 9, Oran, Algeria, for Calendar Year 1944.

Annual Sanitary Report of the U. S. Naval Base Hospital Number 9, Oran, Algeria, for Calendar Year 1945.

Annual Sanitary Report of U. S. Naval Mobile Base Hospital Number 1, Bermuda, for Calendar Year 1941.

Annual Sanitary Report of U. S. Naval Mobile Hospital Number 1, Bermuda, for Calendar Year 1943.

Annual Sanitary Report of U. S. Naval Hospital, Balboa, Canal Zone, for Calendar Year 1944.

Annual Sanitary Report of U. S. Naval Hospital, Coco Solo, Canal Zone, for Calendar Year 1944.

Annual Sanitary Report of U. S. Naval Hospital, San Juan, Puerto Rico, for Year Ending 1944.

Annual Sanitary Report of U. S. Naval Operating Base Dispensary at Londonderry, Northern Ireland, for Year 1943.

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Annual Sanitary Report of the U. S. Naval Dispensary at Base Number 2, Roseneath, Scotland, for Year 1944.

General Sanitary Report of the United States Eighth Fleet for Calendar Year 1944.

General Sanitary Report of the Amphibious Force, United States Eight Fleet, for 1944.

II. Historical Data and Historical Supplement Printed Material

Hospital Reports

Historical Data of U. S. Base Hospital Number 5 at Casablanca, 8 November 1942 to 3 January 1943.

Historical Data of U. S. Naval Base Hospital Number 9, Oran, Algeria, for Calendar Year 1945.

Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative for Period of World War II of U. S. Naval Hospital, Balboa, Canal Zone.

Historical Supplement to Fourth Quarterly Sanitary Report of U. S. Naval Hospital, Coco Solo, Canal Zone, for Calendar Year 1945.

Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II of U. S. Naval Hospital, San Juan, Puerto Rico.

Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative for Period of World War II of U. S. Naval Hospital, Naval Operating Base, Trinidad, British West Indies.

Dispensary Reports

Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative for Period of World War II of U. S. Naval Operating Base Dispensary, Balboa, Canal Zone.

Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative Report for Period of World War II of U. S. Naval Operating Base Dispensary, Bermuda, British West Indies.

Historical Supplement to Fourth Quarterly Sanitary Report for Period of World War II of the U. S. Naval Dispensary at U. S. Naval Advanced Base, Bremen, Germany.

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Historical Supplement to Fourth Quarterly Sanitary Report for Period of World War II of U. S. Naval Dispensary at U. S. Naval Advanced Base, Bremerhaven, Germany.

Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative for Period of World War II of U. S. Naval Air Base, Corinto, Nicarauga.

Historical Supplement to Fourth Quarterly Sanitary Report of the U. S. Naval Dispensary of U. S. Naval Forces Headquarters, Frankfort, Germany, for Period of World War II.

Historical Supplement to Fourth Quarterly Sanitary Report, Cumulative for Period of World War II of U. S. Naval Dispensary at U. S. Naval Operating Base, Guantanamo Bay, Cuba.

Historical Data to Quarterly Sanitary Report of the U. S. Naval Dispensary at U. S. Naval Operating Base, Camp Knox, Iceland, for Period of World War II.

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Historical Supplement to Fourth Quarterly Sanitary Report, Historical Data, December 1945 of U. S. Naval Detachment Dispensary, Marseilles, France.

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Historical Supplement to Fourth Quarterly Sanitary Report of the U. S. Naval Dispensary, Rome, Italy, Cumulative Report of Period of World War II.

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Historical Supplement to Fourth Quarterly Sanitary Report of the U. S. Naval Dispensary at U. S. Naval Operating Base, Trinidad, British West Indies.

III. Letters - General Files

BuMed L5-3/EF(124)A-EC 29 December 1943, Report of Temporary Additional Duty of Rear Adm. Luther Sheldon, Jr.,(MC), USN, to Chief BuMed.

IV. Reports.

Reports of Medical Activity of U. S. Naval Dispensary, U. S. Naval Advanced Base, Cherbourg, France, dated 15 September 1944.

The Annual Sanitary Reports and Historical Data and Supplement matter relative to medical installations indicated in the above bibliographical materials are contained in the files of the Administrative History Section, Bureau of Medicine and Surgery.

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CHAPTER XVI

NAVAL MEDICAL SUPPLY - EXTRA-CONTINENTAL

Section 1 Plans for Overseas Storehouses

To have the men at the fighting fronts protected by an adequate supply of medical materials required an extensive supply network far from the continental United States. Although the Materiel Division was located in Brooklyn, the Medical Supply Depot in Brooklyn, New York, was only one of the chain of depots and storehouses that carried medical supplies around the world. The two great medical supply centers, NMSD, Brooklyn, and NMSD, Oakland, California, dispersed medical materiel to smaller depots and storehouses in the Atlantic and Pacific, respectively.[1] From these overseas depots and storehouses the chain was continued to ships, hospitals, dispensaries, and the actual fighting lines.

Seven December 1941 found no extra-continental medical supply system in existence, except for the storehouse at Pearl Harbor. The Atlantic area had no facilities of any type. The great expansion in the 11 months that followed saw the establishment of four Pacific and one Atlantic storehouses. Prompt plans had been drawn up for the establishment of overseas storehouses in the following locations: Atlantic-Iceland,

1. Abbreviations NMSD and NMSS will be used throughout this chapter for purposes of convenience. NMSD stands for Naval Medical Supply Depot; NMSS, for Naval Medical Supply Storehouse.

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Londonderry, Argentia, Bermuda, Puerto Rico or Tinidad, Recife, and Balboa; Pacific--Kodiak, Mexico, South America, western Australia, eastern Australia, New Zealand, and Samoa.

The basic plan was that these storehouses would carry medical supplies adequate for 10,000 men for 30 days, and from these stores the stock of ships and other activities in the area could be replenished. The chain of supply was to function automatically with supplies being dispatched every 30 days from Brooklyn, where the accounting would be done.

The Force Surgeon, South Pacific Fleet, who had a more immediate view of the needs in his area, made recommendations in terms of coordinating medical supplies for all South Pacific forces. He urged that the basic supply factor be changed to that of medical requirements of 50,000 men for 60 days. He also recommended the establishment of a storehouse at Auckland, New Zealand, and expansion of shipping facilities from the United States to Auckland. He further advocated automatic replenishment for the storehouse which was to provide supplies for advance bases and fill special requisitions for ships.[2]

Neither the original plans nor the suggestions of the Force Surgeon, South Pacific Fleet, were rigidly followed, but were altered on the grounds of expediency. As American forces went abroad, as the pattern of the War shifted, as new combat plans were formulated, storehouses and depots were established, moved, redesignated, disestablished, and

2. Force Surgeon, South Pacific Fleet, to Chief of Staff JJ57/NB(124-41), 13 July 1942.

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reestablished. However, NMSD, Brooklyn, and NMSD, Oakland, remained the terminal points for receiving, processing, and shipping requisitions to the Atlantic and Pacific storehouses, respectively. Much of the story of naval medical supply lay in the work of the extra-continental branches.

Section 2 Pacific Area

The great distances, the major concentration of naval night, and the difficult campaigns anticipated for that theater of war made it inevitable that the Pacific Area should have the larger number of medical supply units. A history of these storehouses follows:

Number	Location	Commissioned	Remarks
1	Noumea, Caledonia	6/20/42	Originally at Auckland, N.Z. Disestablished 8/13/45.
2	Okinawa	7/18/45	Formerly Tutuila, Samoa. Decommissioned 5/1/45. Reestablished.
3	Adak, Alaska	7/29/42	Formerly Kokiak, Alaska
4	Calizan, Samar	8/18/42	Originally Sydney, Australia then Milne Bay, New Guinea
6	Manus, Admiralty Islands	11/10/42	Formerly at Freemantle, Australia Disestablished 12/7/45
8	Balboa, Canal Zone	2/2/43	Redesignated as Medical Supply Depot, 4/17/43
9	Oran, Algeria	3/24/43	Formerly at Casablanca, French Moroco, decommissioned 9/30/45.
10	Recife, Brazil	4/30/43	Transferred to Brazilian Navy 9/13/45.
11	Espiritu Santo, New Hebrides	6/3/43	Disestablished 9/18/45

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Number	Location	Commissioned	Remarks
13	Guam	2/28/45	Redesignated Medical Supply Depot 7/16/45
14	Shanghai	8/2/45	

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For a better understanding of such facilities in terms of necessity, expansion, and adaptability, the work of a few of the Pacific storehouses will be examined in detail.

The establishment of Medical Supply Storehouse Number 1 began with a dispatch from Commander South Pacific Force in which he requested that BuMed initiate action to establish in New Zealand a medical storehouse complete including stores and personnel.[4] He advised that medical stores were not available locally except for emergency purchases of small quantities of limited numbers of items. On 22 June 1942 the Chief of Bureau of Medicine and Surgery recommended to BuPers a Hospital Corps complement for the storehouse and advised that it be supplied by ComSubComSerFor, U. S. Pacific Fleet.[5] On 7 July 1942 the Chief, BuMed informed the Medical Officer in Command, NMSD Brooklyn that the New Zealand Commander had indicated a need for a medical supply storehouse

3. Planning Division, Bureau of Medicine and Surgery Files.
4. ComSoPacFor to OpNav 190415 NCR 8187 dated 20 June 1942.
5. Memorandum - Chief BuMed to Allowances, BuPers P16-1/NB(420622) of 22 June 1942.

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to serve Medical Department activities, ashore and afloat, operating under that command. It was directed that 30 medical maintenance units be assembled and packed as the initial outfit, followed by 10 units every 30 days for 6 shipments, and 5 units every 30 days thereafter. This procedure was intended to provide one year's stock six months after receipt of initial shipment and automatic replenishments every succeeding month.[6] Cominch then gave its approval of South Pacific medical plans which included a medical supply storehouse providing 10,000 square feet of covered storage space, and the shipment of necessary medical stores followed by automatic replenishments. NMSD Brooklyn reported on 31 July 1942 that the stores indicated in BuMed letter of 7 July 1942, had been assembled and shipped as directed. The letter also assumed that the activity would be designated U. S. Naval Medical Storehouse Number 1.[7] OPNAV officially designated the New Zealand storehouse as U. S. Naval Medical Storehouse Number 1.[8]

The usefulness of any supply facility depended upon the nature of the military campaign, the number of men and activities served, transportation, and similar circumstances. The adaptation of storehouses to the military needs of the time was illustrated by the chronicle of NMSS Number 3. The establishment of the storehouse was advocated by the commanding officer, NOB Kodiak, on the plea that increased fleet activity was about to augment the demand for emergency stores.[9] The commandant of the Thirteenth Naval district stated that Kodiak was the logical dis-

6. Chief, BuMed to MO in C, Brooklyn, N9/NB(420707)(SC) of 7 July 1942.
7. MO in C, NMSD Brooklyn to Chief, BuMed L8-2(9922), 31 July 1942.
8. OPNAV to ComSoPacFor - 182122 NCR 6635 dated 19 Aug. 1942.
9. Commanding Officer NOB Kodiak to Commandant 13th Naval District NA34/N-9/N6-40 of 2 July 1942.

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tributing point for emergency material in the Alaskan sector.[10] OPNAV authorized the establishment on 29 July 1942. In August 1943 the officer in charge forwarded a summary to the Medical Officer in Command, NMSD Brooklyn. The permanent buildings were being occupied and 109 requisitions had been received in July 1943. Transportation was such a problem that it appeared that best use of Kodiak would be as a reserve storehouse while the Dutch Harbor and Adak dispensaries could function as branch storehouses. In many cases a full month was required to get supplies to an activity only 300 miles from Kodiak. He asked a decision on the following possibilities: (1) the continuance and maintenance of sufficient stock for the entire area for the maximum six month supply (2) the continuance, but reduction, of stock requirements to a degree sufficient only to supply Kodiak and the occasional ships that call at the post, or (3) the decommissioning of the storehouse and transfer of medical stock on hand to the dispensaries at Adak, Dutch Harbor, and Kodiak.[11] The Medical Officer in Command, NMSD Brooklyn recommended to the Chief of the Bureau of Medicine and Surgery that NMSS Number 3 maintain a reasonable varied stock of medical stores plus a reserve stock. Then it was suggested that NMSS Seattle be expanded to improve logistic support for the Aleutians area.[12] The Chief of the Bureau of Medicine and Surgery replied to the Medical Officer in Command, NMSD Brooklyn that NMSS

10. Commandant 13th Naval District to Chief BuMed, Second Endorsement in 9 (above) - ND13/A1-1/G of 25 July 1942.
11. Personal Letter - Officer in Command, NMSS Number 3, to Rear Admiral Melhorn.
12. MO in C, NMSD Brooklyn to Chief, BuMed L8-2(96003)(99021) of 21 Aug. 1943.

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Number 3 would not be decommissioned at the time and that such a recommendation should come from the area commander.[13] By August 1944, the Officer in Charge of NMSS Number 3 wrote to Admiral Melhorn showing the downward trend in items shipped or delivered during the fiscal year 1944.

1st quarter	--	1124
2nd "	--	890
3rd "	--	270
4th "	--	99

The average was about one requisition every third day. Major dispensaries made more issues than the storehouse, while much of the shipment to the Aleutians was easier from Seattle.[14] The commandant of the new 17th Naval District advised a storehouse at Adak, since the main activities of the 17th Naval District, the Alaska Sea Frontier, Commander North Pacific Force, and various task forces were concentrated there. Thus a medical supply storehouse at Adak would be of real value as an issuing agency for ships.[15] The transfer of NMSS Number 3 from Kodiak, Alaska, to Adak, Alaska, was completed 2 May 1945.[16]

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13. Chief, BuMed to NMSD Brooklyn Serial 1678(SC) of 22 Sept. 1943.

14. O in C, NMSS #3 to Adm. Melhorn - personal letter of 22 Aug. 1944.

15. Com 17 to CNO via BuMed ND17/A1-1(M), Serial 0072, 20 Oct. 1944.

16. Com 17 to CNO via BuMed ND17/A1-1(70), Serial 00981 of 2 May 1945.

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It was virtually impossible for medical supply to remain static as the battle scene shifted and as new areas created new problems in preventive medicine as well as in treatment. The men in the various Pacific areas made invaluable suggestions from their experiences. The Commander, South Pacific Area and South Pacific Force, wrote an analysis of medical supply in his area, offering a plan for an improved system in September 1942. He claimed that the problem was a pressing one which required immediate attention if a critical shortage of supplies and equipment for the care of the sick and wounded were to be avoided. A reservoir of stores had to be set up in a central place because of distance from the United States, the distance between bases, irregular shipping schedules from the United States, and the varying sizes of the activities as well as the fluctuating numbers of personnel. A continuous flow of medical stores from the United States to the reservoir and then to the consuming activities had to be provided, with consideration for such contingencies as: extraordinary demands, expansion in action, increase in personnel complements, and temporary supply for U. S. Army forces, New Zealand and other Allied forces in emergencies, and task forces of the Pacific Fleet. The New Zealand medical storehouse was the logical reservoir except for Samoa. It was, therefore, requested that BuMed approve and implement the plan by immediate shipment to NMSS Number 1 of average annual require-

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ments less the amount already shipped, by similar shipments to the Samoan Islands as soon as requirements were received, and by monthly shipments to NMSD Number 1.[17] BuMed approved the plan and forwarded it to Medical Officer in Charge, NMSD Brooklyn for accomplishment.[18]

Reports from the various fleets were useful to the continental supply depots and the Materiel Division in planning allowances, containers, distribution, etc., for medical supplies and equipment as well as for information about the work of the storehouses and depots. The Service Force, Seventh Fleet, stated that early in 1943 difficulty was experienced in obtaining adequate medical supplies due primarily to shipping problems. The report then suggested that larger quantities of anti-malarials and sulfa drugs should be consigned to the area, and it commented upon the loss of brandy, whiskey, and alcohol because of broken cases.[19]

The historical data of this same group explained how NMSS Number 4 was moved from Sydney, Australia, to Milne Bay, New Guinea. Every three weeks as a building was completed, a shipment was moved to the new location. The move was not too difficult, because a sub-unit which could be expanded had already

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17. Commander South Pacific Area and South Pacific Force L8-1, Serial 00104 of 28 Sept.1942.

18. Second Endorsement, Chief BuMed to MO in C, NMSD Brooklyn, Serial 925 of 31 Oct. 1942.

19. Annual Sanitary Report of the Service Force, Seventh Fleet, for the year 1943, p. 3.

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been set up. In September 1943, Naval Medical Supply Sub-storehouse Number 134, a sub-unit of NMSS Number 4, was established at the Naval Operating Base, Brisbane. Its chief function was emergency issue; by the close of the year, it was being moved to new and larger quarters. Upon the completion of the moving of NMSS Number 4 to Milne Bay, most issues of supplies to island activities could be handled by this sub-unit. Time saved in supplying vessels in port for a short period had justified inauguration of a sub-storehouse. Another sub-unit of NMSS Number 4, planned for Cairns Australia, was not completed in view of the rapidly changing picture.[20] The Fleet Marine Force of the First Marine Division remarked that medical, surgical, and dental supplies had been sufficient in quality and quantity at all times during that year.[21]

The Seventh Amphibious Force commented that most of the landing ships and craft were deficient in combat medical supplies and anti-malarial supplies and equipment. Many landing craft reported without first-aid boxes, and so the standard medicine box plus certain combat supplies and anti-malarials was furnished.[22]

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20. Annex 1, Historical Data, Service Force Seventh Fleet, 1943.

21. Annual Sanitary Report 1943, 1st MarDiv, Fleet Marine Force, p. 16.

22. In this connection the comments from the pharmacist's mate aboard the USS LCI(L) 1066 in the cumulative report for the period of World War II were illuminating:

> "In the States we were told to stock up before leaving. Upon trying to get supplies we were told that they were all in the forward area. At Pearl Harbor...the same old story presented itself. The supplies could be obtained in a forward area. This went on at each step, a day spent trying to get supplies and ending up with nothing."

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There had been no grave deficiencies in supplies, even though it had been necessary to requisition a large number of complete surgical rolls. This force laid its supply problems to lack of shipping within the area for there was no shortage of supplies and equipment in medical storehouses in the Southwest Pacific. Delivery of supplies in time to meet a ship's sailing date was often prevented, and so it was often necessary to obtain stores from Army depots at staging points. Since there were no floating storehouses carrying supplies for emergency issue in the Seventh Fleet, the Fleet surgeon and the Force surgeon obtained additional supplies for their flagships to be made available for issue in forward areas. The Service Force was then organizing standard loads of medical supplies that would be available in certain AK-type ships.[23]

Capt. F. H. Hook stressed another vital point when he recommended that all penicillin for the area be sent to NMSS Number 11 for distribution to avoid immobilization of it in hospitals that did not then need it.[24]

The medical department of the Seventh Fleet reported that medical stores were arriving in sufficient quantity after a previous shortage of atabrine, mosquito netting, surgical and

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23. Annual Sanitary Report of the Seventh Amphibious Force for the year 1944, p. 2.

24. Letter to Vice Adm. R. T McIntire, 31 Jan. 1944.

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dental instruments, and sulfa drugs. In light of past issues, excessive amounts of glucose, saline, and blood plasma were on hand. Equipment furnished the medical functional units was on the whole excellent. However, the field autoclave was not satisfactory, for the pressure door frequently blew off; the portable dental set was obsolete, for such units made no provision for using electric power. Electric power was usually available from portable or other type generators wherever dental units were used.[25]

Meanwhile reverse lend-lease was proving useful in such an emergency as the non-arrival of equipment for Mobile Hospital Number 6. On 3 March 1944, the medical officer in command of Base Hospital Number 4 reported that activity's procurement of $6,897.76 worth of medical supplies from the New Zealand Army Medical Service.[26]

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25. Medical Department Activities, Seventh Fleet, A3-1(F-4-2/rlh), 20 Feb. 1944, p. 4.

26. 8 July 1942 the Secretary of the Navy had issued instructions to forces afloat and abroad to arrange for receiving services, facilities, and equipment locally.

The report of reverse lend-lease under cognizance of BuMed, cumulative through 30 June 1945 (A16-4/EG), displayed how these instructions had been found valuable:

Australia		New Zealand		United Kingdom	
1942	$19,721.68	1942		1942	
1943	38,121.85	1943	$143,976.01	1943	$5,615.69
1944	37,752.78	1944	67,320.19	1944	19,368.74
1945	13,186.43	1945	104,625.37	1945	14,628.12

France		India	
1942		1942	
1943		1943	
1944	$2,831.54	1944	
1945	2,998.13	1945	$13.92

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An increasingly serious problem was the breakdown of electro-medical and dental equipment in forward areas. In order to hasten repairs and so shorten the time such equipment was not in service, the Surgeon General authorized an electro-medical and dental repair unit at NMSD Pearl Harbor in March 1944. In the first three months of its existence this unit had accomplished 1,168 vital repairs.

The Inspector of Medical Activities, Pacific area, stated that medical supplies in the whole Tarawa area were ample in all respects at that time.[27]

Although it was generally encouraging, the November report of the Medical Inspector, Pacific areas, pointed out new difficulties. He mentioned that the requisitioning activity did not know for two or three months what items had been deleted by the Island Command, the Commander Forward Areas, or the supply depot. He felt it would be of assistance, if the depot sent a copy of the requisition and the changes to the originating activity. Supplies for Tinian and Kwajalein were ordinarily satisfactory. A wrecked ship resulting in the loss of 50 to 65 percent of the stores, and inadequate storage space were Saipan's problems. NMSS Number 13 on Guam could begin issue of supplies within 20 days, for it

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27. Office of Inspector , Medical Department Activities, Pacific area, 21 Mar. 1944.

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had 30 block shipments on hand. There was only one building, however, and four automatic shipments were yet to arrive. The block shipments should have included more boric acid, bismuth, codeine, and paregoric, and a bottle of mercury. Ulithi's store of biologicals was dangerously low; only one block shipment had arrived and that 45 days after D-day. Majuro was also short of supplies as was Base Hospital Number 20 on Peleliu. The hospital's shortage was due to two errors: (1) prosthetic dental material taken off the ship at Manus was allowed to deteriorate so that some of it had to be sent to NMSS Number 6 for salvage, and (2) needed laboratory equipment was landed on Saipan instead. The underlying difficulty was that base hospitals, unlike the fleet hospitals, were not adequately provided with initial equipment.[28]

The Service Force, Pacific Fleet, implemented the program set up by the naval medical supply depots by operating its own medical supply facilities in the forward areas. The following stores' issue and general stores' ships were set up to issue medical stores: the USS CASTOR, LUNA, GIENSAR, SHAULA, AZIMECH, ASCELLA, CHELAB, RUTILICUS, VOLANS, TALITHA, and ALKES. In the absence of stock or in case of depletion of stock on these ships, there were these additional sources of medical supplies: the USS SILICA, MARL, and LIGNITE, and the YF's 738, 739, 740, 742, and 787.[29] Commander

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28. Office of Inspector, Medical Department Activities, Pacific Area, to Vice Adm. McIntire, 25 Nov. 1944, pp. 3, 5, 7, 18, 22, 23.

29. The value of such a system to ships in the area may be seen from the brief statement incorporated in the cumulative report for the period of World War II, USS TETON (ACG-14)

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Service Squadron Ten and his representative for the locality exercised control over this supply system and were empowered to screen and approve requisitions prior to issue. Items and amounts issued were governed by acuteness of need and the amount available for issue. Requisitioning ships were to be prepared to carry their own supplies.[30]

The historical report for 1944 of the Service Force, Seventh Fleet, presented a picture of crises in supply. On 30 June 1944, the Seventh Fleet was committed to the logistic support of approximately 100,000 men of the Third Fleet from 27 August to 31 December 1944. To meet this assignment, NMSS Number 6, Freemantle, Australia was ordered to Manus, Admiralty Islands, where it arrived 18 August. The stock was immediately reduced to a negligible amount by the demands of Third and Fifth Fleet units afloat which had apparently arrived in the Pacific Ocean areas without even a minimum stock of medical supplies aboard. Despite the fact that protests were dispatched to the Commander Pacific Ocean areas, and to the Bureau of Medicine and Surgery, ships continued to arrive

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"We did contact several supply ships, usually AKA's and procured some of the things we had run low on. In fact, from these supply thips we were able to build up to the required amount many items that we became critically low on."

30. Pacific Fleet Medical News, vol. 1, No. 3, Dec. 1944, quoted in U. S. Navy Medical Supply News Letter, Issue 3-45, 1 Mar.

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expecting to requisition whole stocks from NMSS Number 6. It was estimated that the storehouse was supplying 200,000 men instead of the 100,000 originally considered. Demands on the storehouse did not materially lessen, and so the supply situation remained critical until the end of the year when increased supplies began to arrive. Meanwhile on 6 October 1944, word was received that Hollandia was to be one of the major Seventh Fleet staging and resupply points for the Leyte operation. On 10 October, this command ordered a medical supply facility transferred from Finschhafen to Hollandia. The crisis there was relieved only by the excellent cooperation of the Sixth Army Service Supply which arranged the furnishing of medical supplies by Army medical supply depots. This plan was still operating at the end of the year, for naval facilities continued inadequate. It was felt that by the date of their completion such facilities would be unnecessary.[31]

The Seventh Fleet offered two suggestions for improving the supply situation: (1) that all ships leaving the continental United States or other bases, where stocks of medical supplies were ample, should be fully loaded with a complete stock (six months' supply), and (2) there should be floating NMSS's of at least three barges of the YF-787 type.[32]

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31. Service Force, Seventh Fleet 1944, Appendix A - Historical Data.

32. Annual Sanitary Report of the Seventh Fleet for the year 1944.

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The Service Forces, Seventh Fleet, blamed its supply problem on failure to request sufficient materials for the overall personnel to be served. This condition was brought about by lack of timely information as to logistic supply of forces afloat, other than the Seventh Fleet. At the close of the year medical supplies on hand and on order were considered adequate. Optical units had been unable to meet the demand for spectacles by many who had never worn them before or who had only slight to moderate refractive errors. Medical components commonly had been attached to units in their formative stages and, since equipment and supplies had been assembled elsewhere, these personnel did no useful service for long periods.[33]

The Inspector of medical department activities, Pacific Ocean area, stated on 10 January 1945, that there were no medical supply barges in the South Pacific. Medical supply replenishments were obtained from NMSS Number 1, NMSS Number 11, the medical supply facility at Guadalcanal, and the non-official medical storehouse attached to the Naval Base, Tutuila. It was considered that the latter should be a regularly constituted storehouse for the supply facilities in the Samoan group. Work done by the five optical units located in the South Pacific, as well as other Pacific areas, had been most valuable.[34]

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33. Annual Sanitary Report of the Service Force, Seventh Fleet, for the Year 1944.

34. Report of Inspection of Medical Department Activities, Pacific Ocean Areas, 10 Jan. 1945, p. 3.

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Rear Admiral Melhorn reported to the Surgeon General referring to a letter from Capt. J. P. Wood that there were delays in shipment to the Southwest Pacific area. Captain Wood stated that no ships were available until June, and that shipment after shipment had been cancelled after the material had been prepared to meet datelines. The last medical stores shipped to the Southwest Pacific had cleared the port of San Francisco in February.[35]

The extent of medical supply resources and facilities in the Pacific by September 1945 was impressive. The chief source was the Medical Supply Depot, Guam, which was the central stocking point for biologicals and special vaccines, its annex at Saipan, and Medical Supply Storehouses Numbers 6, 4, and 2 which was yet to be established. Supply barges, the USS SILICA, LIGNITE, and MARL, and YF's 787, 738, 739, 740, and 754 were moved to points of ship concentration as necessary. Certain AK and AKS vessels, the ALKES, ASCELIA, AZIMECH, CAELUM, CHELEB, GIANSAR, LEONIS, LESUTH, MATAR, PHOBAS, RUTILICUS, SHAULA, ALCYONE, MERCURY, CASTOR, CYBELE, ORATIA, HECUBA, HESPERIA, IALANA, KOCHAB, LIGURA, LUNA, TATITA, VOLANS, ALCHIBA, and THUBAN, carried a broad list of expendable medical and dental supplies. 40 vessels of Commander Service Squadron 6 had ready packed loads

35. Memorandum (Personal and Confidential) to Surgeon General from Rear Adm. K. C. Melhorn, 27 Apr. 1945.

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providing 60 days' usage of expendable supplies for emergency issue to advanced task units. Separate requisitions were to be made for biologicals, precious metals for dental use, other dental items, remaining Medical Supply Catalog items, and all items not listed in the Catalog. Certain general suggestions were made to simplify the problem: (1) unusual requests should be justified, (2) requisitions should be discussed with the officer screening and filling them, (3) trips to A.K's and barges should be coordinated with those of the supply officer, and (4) all ships should try to replenish their stock from the nearest medical supply facility.[36]

The latest epitome of naval medical supply in the Pacific area was made in December 1945 with a view to permanent post-war supply.[37]

Section 3 Atlantic Area

In the Atlantic area, the fleet was concerned with convoy duty, anti-submarine patrol, transporting of troops, and support of invasions, much as was the case in the Pacific. These duties dictated the location of medical supply storehouses, but with the smaller area and greater concentration of forces, fewer facilities were necessary. The Atlantic storehouses were as

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36. "Pacific Medical News," vol. 1, No. 12, 19 Sept. as reported in U. S. Medical Supply News Letter of 10 Oct. 1945, Issue No. 10-45.

37. Pacific Naval Supply Handbook, Dec. 1945, Commander Service Force, Pacific Fleet, pp. J 1-3. See appendix A.

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follows:

NUMBER	LOCATION	COMMISSIONED	SHIPPING DESIGNATION	REMARKS
5	Londonderry, North Ireland	10/21/42	SPUR	Decommissioned 9/2/44
7	San Juan, Puerto Rico	2/2/43	ABOW	Disestablished 9/30/45
12	Exeter, England	10/23/43	JOWL	[38]

The Atlantic area provided one of the most dramatic supply stories of World War II in the case of NMSS Number 12, Exeter, England. Officially established 23 October 1943, with only 12 men as a working staff, it had received 50 to 60 percent of its initial stock of medical supplies by 28 February 1944.[39] Although its original purpose had been to furnish medical supplies for 60,000 men, it was rapidly reorganized to supply 100,000. Its physical plant beginning with five buildings had been increased to 36 which provided 16,000 square feet of storage space. By November 1944 it was receiving 642 cases in the same period.[40] The greatest crisis of NMSS Number 12 was its preparation for D-day at Normandy which included: (1) providing 100 Army and Navy property exchange units for LST-type vessels;

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38. Planning Division, M & S files.

39. Annual Sanitary Report, Commander Twelfth Fleet for year enging 31 Dec, 1944, pp. 7-8.

40. NMSS #12, Historical Report, Nov. 1944.

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(2) redistributing medical stores from LST's having excessive quantities to the 103 LST's designated for casualty evacuation; (3) distributing 62,400 blankets to casualty carrying LST's; (4) distributing 62 officers' emergency surgical outfits; (5) providing temporary additions to commissioning allowances of ships; (6) replenishing commissioning allowances of the 103 casualty carrying LST's as well as of 50 other LST's; (7) making shipments to 10 accommodation ships, battleships, cruisers, destroyers, destroyer escorts, and other miscellaneous craft; (8) stocking and replenishing the resupply points for resupplying LST's at the end of each trip and (9) supplying and replenishing hospitals and dispensaries. In the six weeks before D-day, 28,550 cases of medical stores were shipped. A letter of commendation from Admiral Stark was received for this work.[41]

The Commander of Amphibious Bases, United Kingdom, complimented NMSS's Numbers 5 and 12 upon their handling of supplies. Medical and surgical supplies and equipment were distributed to all ships, and arrangements were made for resupply of these items from medical supply dumps at turn-around points on the near shore. All supplies from the United States arrived in small shipments aboard LST's so that distribution was complicated. Although it would have been simpler to have all supplies

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41. NMSS # 12 Report, 15 Apr. 1944 to 1 Sept. 1944.

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sent to a central dump and thence reallocated, neither time nor shipping permitted this. One improvement suggested was the devising of a water tight container for alcohol being shipped overseas.[42]

The Amphibious Force, U. S. Eighth Fleet, suggested that since there was little difference between medical supplies used by the Army and the Navy, joint Army-Navy medical supply catalogs and equipment were entirely feasible. Most supplies and equipment for this Force came from NMSS Number 9, but at one base a fairly well-stocked storeroom was instituted from which amphibious craft could drain in small amounts for current replacement. In preparation for military operations, blankets, metal pole litters, and plasma were obtained in quantity from Army medical supply depots. Although the quality of supplies was excellent, containers could have been improved. Two examples of the dangers of packaging in inadequate containers were the rapid deterioration of plaster of Paris in cellophane-covered cardboard containers, and the loss of boric acid packed in one pound cardboard containers. These cardboard containers frequently broke in transit.[43] The Fleet medical officer of the Eighth Fleet stated that the transportation and flow of supplies had improved since 1943. The transfer of NMSS Number 9 from Casablanca to

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42. Annual Sanitary Report of Commander Amphibious Bases, United Kingdom, year ending 3 Dec. 1944, pp. 7, 11.

43. General Sanitary Report of the Amphibious Force, U. S. Eighth Fleet, 1944.

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Oran was advantageous both for supplying activities and for receiving supplies and equipment being decommissioned.[44]

Conclusion

To meet the problem of supply overseas, it can be seen from the foregoing that the basic formal plan had to be modified with considerable improvisation. This resulted in much variation in local conditions, but it succeeded in a satisfactory manner. Thus the Service Force, Seventh Fleet, had set up Sub-storehouse Number 134 at NOB, Brisbane; the Fleet and Force surgeons of the Seventh Amphibious Force had obtained additional supplies for issue in forward areas by their flagships; a medical supply facility was set up at Guadalcanal; and a non-official medical storehouse was operated at Tutuila. A further departure from set plans was the use of supply barges, YF's, AK's, and AO's to carry replenishments ranging from ready packed loads of 60 days' usage of expendable supplies to broad lists of expendable medical and dental supplies. Lack of shipping space, rapid movement of forces, inadequate containers, and the arrival of ships lacking initial outfits in forward areas were the major problems. Constant changes and developments during the war years, such as the Automatic Stores Replenishment Catalog, the shifting of storehouse locations, and the creation of an electro-medical dental repair unit, were aimed at solving these problems.

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44. General Sanitary Report for calendar year 1944, Fleet Medical Officer, U. S. Eighth Fleet, pp. 4-5.

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APPENDIX A

SECTION J

MEDICAL SUPPLIES

Pacific Naval Supply
Handbook December 1945

PART I. SYSTEM AND PROCEDURES.

Requisitions and Sources of Supply:

Ships submit requisitions for medical supplies to the nearest medical supply facility. Such a facility may beneither a minor medical supply point ashore or a mobile floating storeship (attached to a ServDiv) stocked with medical supply units. MSS's (ashore) are located at Subic, Samar, Manus, Saipan, and New Caledonia.

Shore bases make requests on the nearest Medical Supply Storehouse, or if nearer, on one of the two Medical Supply Depots, NMSD, Guam or NMSD, Pearl. NMSD, Guam, serves all area and the MarGilsArea.

Medical Storehouses (MSS's) secure their replenishment stocks of supplies from the NMSD at Guam.

YF and IX barges submit their requisitions to NMSD Guam.

All activities use NavMed Form 4 for requisitioning purposes.

Screening:

All screening is local in character, each medical supply activity reviewing requisitions it receives and determining without further reference whether or not such requisitions should be filled and in what amounts.

Stock Control:

Once each month all medical supply activities prepare an Inventory Report showing stocks on hand, on order and issued. The original of this report goes to

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BuMed and ComServPac receives a copy. While no formal, specific control methods are predicated on this report, it serves ComServPac as a guide for general analysis of the medical supply situation in the Pacific, and as a basis for action necessary to adjust or increase stock in the area.

Stock Levels:

Medical Storehouses and NMSD's maintain stock levels, established by ComServPac on BuMed authority, of 6 months to 9 months supply.

YF's and IX's maintain sufficient stock to take care of 50,000 men for 30 days.

Medical Supply Activities Currently Operating:

NMSD Guam
NMSD Pearl
MSS No. 1, Subic
MSS No. 4, Samar
MSS No. 6, Manus
MSS No. 13, Saipan
Supply Facility Fleet Hospital 105, New Caledonia

USS SILICA (IX-151)
USS MARL (IX-160)
USS LIGNITE (IX-162)
YF 738
YF 739
YF 754
YF 787
YF 740

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B I B L I O G R A P H Y

MEDICAL SUPPLY (Extra-Continental)

I. BUREAU OF MEDICINE AND SURGERY

A. General Files

Medical Officer in Charge, NMSD, Brooklyn, to Chief Bureau of Medicine and Surgery, JJ57/NB(124-41), 15 June 1942.

Force Surgeon, South Pacific Fleet, to Chief of Staff, JJ57/NB(124-41), 13 July 1942.

COMSOPACFOR to OPNAV, 190415 NCR 8187, dated 20 June 1942.

Memorandum Chief, BuMed to Allowances, BuPers, P116-1/NB (420622) (SC) dated 22 June 1942.

Commanding Officer, NOB Kodiak to Commandant 13th Naval District, NA34/N-9/N6-40 of 2 July 1942.

Commandant 13th Naval District to Chief, BuMed, Second Endorsement on NA34/N-9/N6-40, ND12/A1-1/G of 25 July 1942.

Personal letter O in C, NMSS No. 3 to Rear Adm. K. C. Melhorn, 10 August 1943.

Chief, BuMed to MO in C, NMSD, Brooklyn, N9/NB(420707)(SC) of 7 July 1942.

MO in C, NMSD, Brooklyn, to Chief, BuMed, L8-2(9922) of 31 July 1942.

OPNAV to COMSOPACFOR, 182122 NCR 6625, dated 19 August 1942.

MO in C, NMSD, Brooklyn, to Chief, BuMed, L8-2(96003) (99021) of 21 August 1943.

Chief, BuMed to NMSD, Brooklyn, Serial No. 1678(SC) of 22 September 1943.

Personal letter from O in C, NMSS No. 3, to Rear Adm. K. C. Melhorn of 22 August 1944.

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Com 17 to CNO via BuMed, ND17/A1-1(M), Serial 0072 of 20 October 1944.

Com 17 to CNO via BuMed, ND17/A1-1(70), Serial 00981 of 2 May 1945.

Commander South Pacific Area and South Pacific Force, L8-1 Serial 00104 of 28 September 1942.

Second Endorsement, Chief BuMed to MO in C, NMSD, Brooklyn, on L8-1 Serial 00104, Serial 925 of 31 October 1942.

Memorandum (personal and confidential) to Surgeon General from Rear Adm. K. C. Melhorn, dated 27 April 1945.

Capt. N. H. Hook to Vice Adm. R. T McIntire of 31 January 1944.

B. Historical Data and Annual Sanitary Reports

Supply Depots and Storehouses:

USNMSD, Brooklyn, and Materiel Division, cumulative, 10 November 1945.
NMSS No. 3 (Kodiak), 1944
NMSS No. 7 (San Juan), 1944
NMSS No. 11 (Espiritu Santo), 1944
NMSS No. 12 (Exeter), 1944
NMSS No. 13 (Guam), 1944
NMSS No. 10 (Recife), 1944
NMSD, Balboa, 1944

Fleets and Fleet Units:

Service Force, Seventh Fleet, 1943
Annex 1 - Historical Data - Service Force, Seventh Fleet, 1943
First Marine Division, Fleet Marine Force, 1943
Seventh Amphibious Force, 1944, Appendix A - Historical Data.
Service Force, Seventh Fleet, 1944.
Seventh Fleet, 1944, Medical Department Activities, A3-1 (F-4-2)
Service Force, Seventh Fleet, 1944, Appendix A
Commander, Twelfth Fleet, 1944
Commander, Amphibious Bases, United Kingdom, 1944
Amphibious Force, Eighth Fleet, 1944
Fleet Medical Officer, Eighth Fleet, 1944
Cumulative Report for Period of World War II, USS LCI(L) 1066, n. d.
Cumulative Report for Period of World War II, USS TETON (AGC14), n. d.

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C. Special Reports

Inspector, Medical Department Activities, Pacific Area, dated 21 March 1944.

Inspector, Medical Department Activities, Pacific Area, dated 25 November 1944.

Inspector, Medical Department Activities, Pacific Areas, dated 10 January 1945. Reverse Lend Lease under cognizance M & S, Cumulative, through 30 June 1945, A16-4/EG.

D. BuMed Classified Files

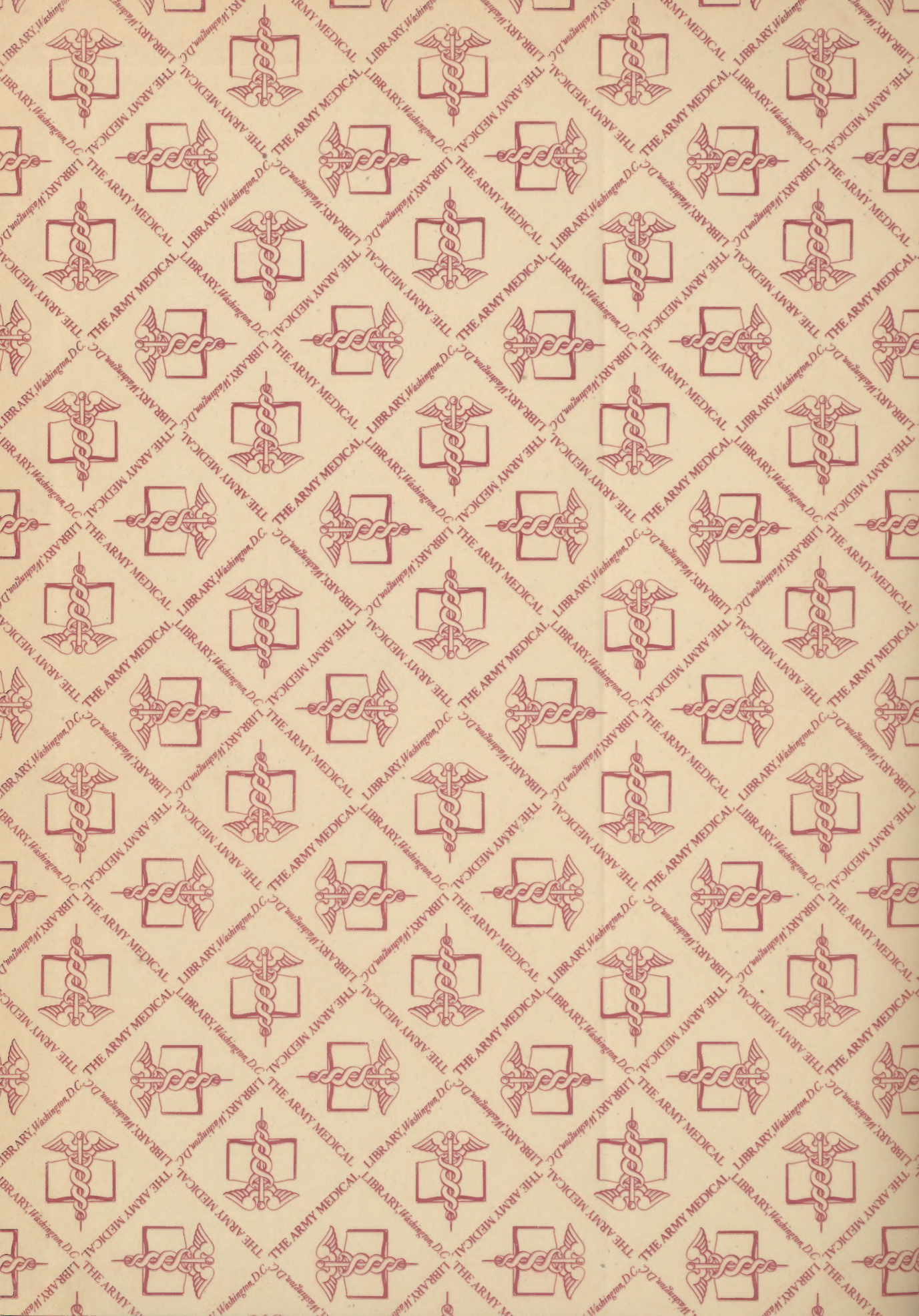
Planning Division:
Listing of numbered storehouses and extra-continental supply depots

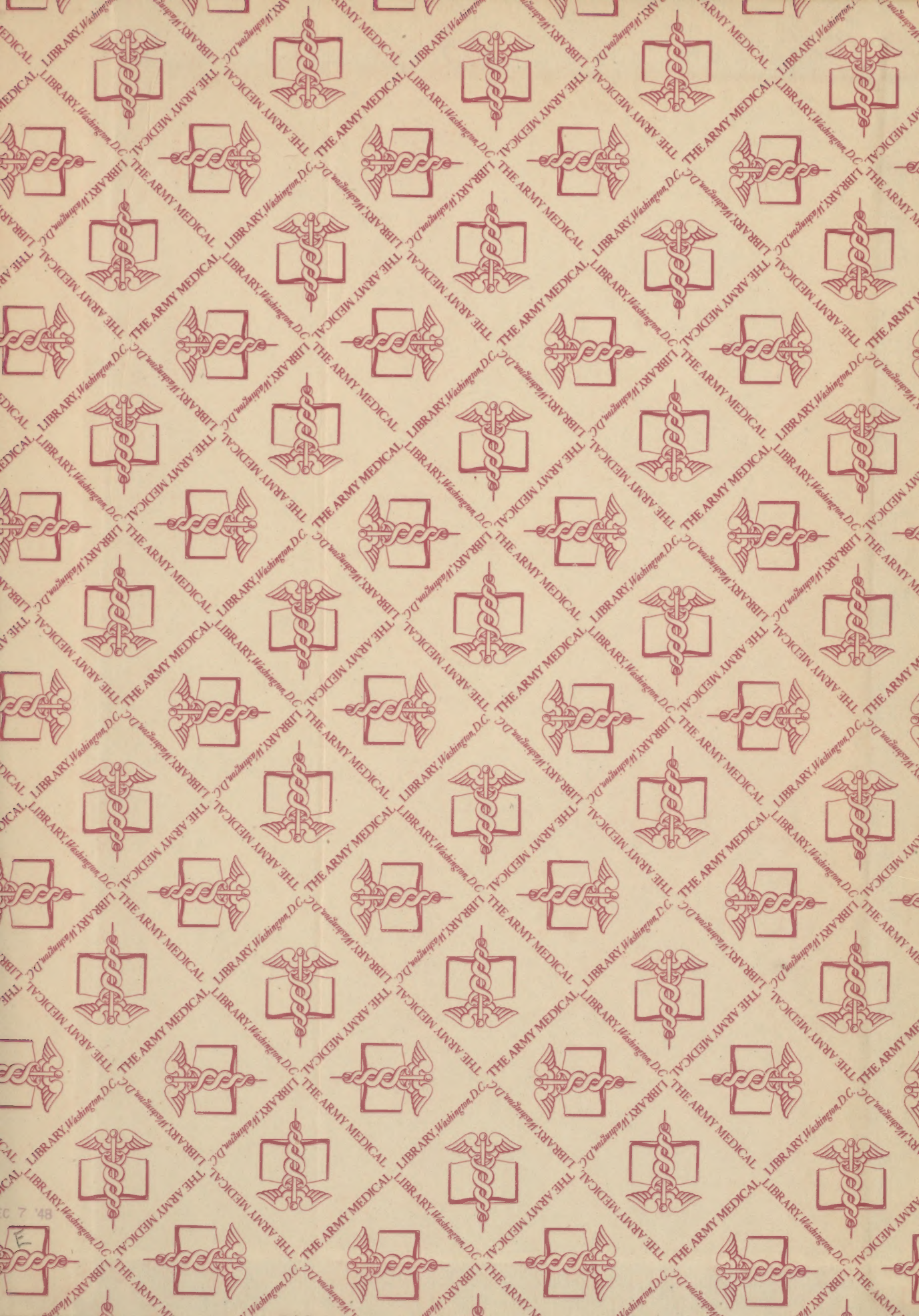
Finance Division:
Lend Lease Statistics

E. Medical Department Publications

U. S. Naval Medical Supply News Letter, 1943-1945.

Pacific Naval Supply Handbook, Commander Service Force Pacific Fleet, Section J, Medical Supplies, December 1945.


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